

**POST KATRINA HEALTH CARE: CON-
TINUING CONCERNS AND IMMEDIATE
NEEDS IN THE NEW ORLEANS REGION**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS

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POST KATRINA HEALTH CARE: CONTINUING CONCERNS AND IMMEDIATE NEEDS IN THE NEW ORLEANS REGION

TUESDAY, MARCH 13, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 2123 of the Rayburn House Office Building, Hon. Bart Stupak (chairman of the subcommittee) presiding.

Members present: Representatives Stupak, DeGette, Green, Inslee, Dingell [ex officio], Whitfield, Walden, Ferguson, Burgess, Barton [ex officio], and Blackburn.

Staff present: John F. Sopko, Christopher Knauer, Kristine Blackwood, Scott P. Schloegel, Rachel Bleshman, Lauren Bloomberg, Alan Slobodin, Peter Spencer, and Krista Carpenter.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. I will call this hearing to order.

Today we have the hearing on Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Area.

It has now been over a year-and-a-half since Hurricane Katrina touched land on August 29, 2005. Nearly a year ago, this subcommittee held a hearing in New Orleans to examine public health care conditions in the region. What we found then was a system overwhelmed with far more patient demand than capacity. Since that time this committee has continued to monitor and assess the ongoing health care needs faced by those in the New Orleans region.

A few weeks ago, our majority and minority committee staff returned from the area to report on where health care stands today. Unfortunately, what our staffs found is that much of the region's health care structure still remains crippled and major problems remain unresolved. In the four worst-hit parishes of Orleans, Plaquemines, Jefferson, and St. Bernard, the loss of hundreds of thousands of homes and the closure of many health care facilities displaced thousands of physicians, mental health providers, nurses, dentists, obstetricians, lab technicians, and other allied health professionals.

While estimates are that approximately half of the city's former residents have returned, it appears that many of those previously employed in the health care sector have found work elsewhere and may not return. Many specialists and support staff are in high demand in other parts of the country. This demand continues to place significant pressure on New Orleans' outpatient clinics and hospitals to attract needed medical personnel. At the same time, the region has experienced an influx of construction workers and day laborers who often lack insurance.

Key hospital facilities remain destroyed or closed. The flagship hospital for the State-run public health system in downtown New Orleans was known as Big Charity. Big Charity was the predominant source of healthcare for the large percentage of poor and uninsured. It will never reopen in the old building, and a path to building a new hospital is littered with controversy and obstacles. In addition, privately owned Methodist Hospital and Chalmette Medical Center, which provided hospital services for residents east of the city, are closed.

[Slide shown.]

This is what these two hospitals look like today. We have one back here. Here we go. At Chalmette, we got what, about four of them?

[Slide shown.]

That is the Wal-Mart parking lot. You can see the trailers that are right there. We are providing some health care right now.

[Slide shown.]

And that is Methodist Hospital. There is a fence around it. It is not open for business but there is a fence around. It is hard to see. If that was a real hospital, you would see more than just two cars around there. Next facility? That is it? OK.

Hospitals that were able to remain open during the storms or have since reopened continue to struggle with critical staffing shortages, rapidly spiraling costs, and inadequate or delayed reimbursement. These challenges are compounded as they treat New Orleans' poor and uninsured who were previously provided for by Big Charity.

Many of today's witnesses have made tremendous personal sacrifice to help their community and its medical infrastructure recover while they cope with the loss of their own homes and neighborhoods. Along the way they forged many new and innovative partnerships. Their courage and heroism is an inspiration to us all. It is clear, however, that there is so much more to be done and soon.

Our hearing today will focus on what the health care providers believe are the most urgent health care issues that need to be addressed in the short term. For example, as debate continues about when, where, how big, or even whether to rebuild a charity hospital in New Orleans, there is no consensus on how to cost-effectively deal with the growing number of uninsured and underinsured patients now flowing into the region. Many who were once able to rely on Charity Hospital must now turn to either University Hospital, which has only 100 beds, or travel to other parts of the State for treatment at one of the State's other public hospitals. Traveling for health care is impractical for many residents, particularly given

the transportation problem still plaguing the State. Others are seen by the region's private hospitals. However, aside from loading an uninsured with complications from diabetes into an ambulance and delivering him or her to an emergency room, the most expensive avenue of treatment, there is no way to allow an uninsured patient to easily access private care.

Because Louisiana State law has directed that the bulk of the Medicaid disproportionate share, DSH, dollars go to the State Public Health Care System, significant challenges remain about how to allow the uninsured access to existing capacity while providing fair compensation to the doctors and hospitals that provide the care.

Given that Big Charity is no longer viable and won't be for at least 5 to 7 years, access to health care for the uninsured and poor must be resolved. And while we must find a way to compensate those private hospitals that are currently providing care, we must also ensure that private hospitals shoulder the full spectrum of the uncompensated care patients, not just the healthiest. All this must be done in a way that is reasonably fair to both the institution and the taxpayers.

Another area that must be addressed immediately involves the many outpatient clinics now providing critical safety-net care. Many of these clinics, including those that make up the PATH network, are seeing patients that otherwise would have little or no access to healthcare services. These clinics are filling critical health care needs where there was once a public hospital and clinic system. They also provide ambulatory and preventative care that would otherwise require an expensive trip to the emergency room.

Nonetheless, more needs to be done to integrate these important health care providers into the existing hospital structure and reimbursement structure. For example, if someone with complications from diabetes shows up at a small primary care clinic, there is no formal way to refer him or her to the surrounding hospitals, particularly a private hospital other than placing the patient in an ambulance and sending him to the emergency room. If the patient is under- or uninsured, this makes the effort even more daunting. As these clinics are often working on small budgets comprised of donations and small grants, a formal mechanism to reimburse them for the care they provide must be explored. These clinics will play a significant role in providing care for the region's poor for the foreseeable future.

Another area that needs immediate attention is the State's ability to train its own health care providers. The New Orleans region was a significant training center for the State's future doctors, nurses, and other health care practitioners. Since both of the primary teaching facilities, the Veterans Hospital and Big Charity, were destroyed, the region's two medical schools, LSU and Tulane, have struggled to keep their teaching programs together. And while LSU and Tulane have managed to hold many of their programs together by placing their students around the region in other hospitals, this stop-gap measure will only last so long.

As reported to this committee by officials from both medical schools, key programs have already lost accreditation and others are now threatened. Shoring up the region's medical schools and teaching facilities is a significant urgency, and this alone will be

a daunting task. A solid plan must be developed for LSU and Tulane so they can continue to train much-needed health care professionals.

I want to talk for a minute here about the model that has been used so far to attempt to address some of the rather daunting health care challenges that have faced the region post-Katrina.

Last year the Secretary of Health and Human Services asked the State to come up with a plan to fix the region's health care infrastructure including some of the issues I just raised. That process became known what is generally referred to as the Collaborative, and it is a very important chapter in the State and Federal Government's response to the region's post-Katrina health care needs.

The Collaborative plan brought together a vast array of stakeholders, public and private, State and local, to find ways to restructure health care delivery system for the area's most affected by the storm. This area referred to as region 1 encompass Orleans, Jefferson, St. Bernard, and Plaquemines Parish. While many of the participants in the Collaborative had significant differences of opinion, they worked hard to achieve consensus on some major points.

Last October the Governor submitted the Collaborative plan to the Department of Health and Human Services. What came back from HHS just a few weeks ago appears to be a proposal that is very different in both size and scope than what the State sent to HHS. Instead of working on the various points of consensus and rolling out a pilot plan for region 1, HHS answered with a plan to replace Louisiana's statewide public health hospital system with what appears to be an insurance model. Putting aside the various HHS plans or one view on the State's public health care system, HHS's plan may simply be too ambitious at this point in the recovery process. Applying just some of the concepts of the Collaborative merely to region 1 would be difficult enough, but having Louisiana implement a sweeping, statewide redesign of its complex, publicly funded hospital system, may simply be unworkable in the current environment. While HHS may have good intentions in this effort, much smaller bites of the apple must be taken if we are going to provide access to health care in New Orleans.

Unfortunately, the State and Federal Government now appear to be at an impasse. Instead of breaking off pieces of a complex health care system and forging ahead with ways to solve each piece, I fear that the State and Federal Government will become locked in a colossal fight of dooming spread sheets and armies of actuaries. Answering the question whether HHS proposal can work or would instead obliterate the safety net for hundreds and thousands of low-income residents across the whole State as Louisiana's Secretary of Health and Hospitals now suggest seems less important in the amount of time and energy that will be expended in this fight. Perhaps rather than one-size-fits-all plan, the Secretaries of Health for both the State and Federal Government should attempt to address smaller portions of this problem and provide health care of all the citizens in region 1.

There is an old African proverb that goes something like this. When elephants fight, it is the grass that suffers. I am afraid that is where New Orleans region finds itself with health care today.

Tremendous energy is already gone into attempting to solve the health care needs of the region.

My admiration goes out to all the witnesses that are in this room today, those representing small clinics, those representing public and private hospitals, and those representing both the State of Louisiana and the Federal Government. Each of you has greatly contributed to keeping the region alive through your creativity and your countless hours of service. Nonetheless, I fear if you do not find new ways to work together on these issues soon, the health care situation in the region may grow worse.

Let me be clear as to why we are here today. The hearing is not about pointing fingers, nor is it about attacking one another. I understand that many of you have very valid philosophical differences about how to get the job done; but frankly, you all work too hard to allow this ongoing effort to be balled into a bigger exercise of blaming one another for poor choices. Instead, I challenge you to use today's hearing as the opportunity to seek common ground.

I am looking forward to hearing from each of you about what problems you think need immediate focus and some proposals for ways we might be able to work together, the Congress, the executive branch, State and local government, private and public providers, to address the health care needs of your region. Too many lives are counting on your collective efforts, and I intend to do my best to use this committee to play our small part.

Let me conclude by again thanking every witness that will be testifying here today. Many of you have taken great expense to be here and have left your practices of providing needed health care to the region to be here. Your input and willingness to be here is boldly commendable and appreciated by us and the people in the New Orleans region.

Let me also thank my colleagues on the other side of the aisle. Mr. Whitfield, you and many of the colleagues on both sides of the dais have been particularly gracious with your time and attention to this matter. Moreover, I want to thank our staffs for their excellent input they have provided into this inquiry. I look forward to working with all of you as we continue to stay involved in this critical matter.

With that, I now yield to my good friend from Kentucky, Mr. Whitfield; and I would just remind our witnesses, we have four hearings this week in Energy and Commerce Committee. Mr. Dingell is overworking us and underpaying us, but Members will be coming in and out. So you will be seeing people coming in and out all day.

And with that, Mr. Whitfield, great to be with you for your opening statement, sir.

OPENING STATEMENT OF HON. ED WHITFIELD, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. WHITFIELD. Chairman Stupak, thank you. And I also want to thank those witnesses who have come from the New Orleans area to testify today on this important topic. I would suspect that if there is any group that has been overworked and underpaid over the last few years it is this panel of witnesses, in fact, all three

panel of witnesses; and we genuinely appreciate the great effort that you all continue to make in the New Orleans area.

I remember January 2006 this subcommittee came to New Orleans and held a hearing on the state of health care delivery post-Katrina. And we know as I said earlier you have met many challenges that have been extremely difficult, and all of us have been amazed at the progress that you have been able to make in the New Orleans area, but we also understand that you have a long way to go. And from the testimony that I have read that will be given today, access to care continues to be limited with critical shortages of mental health, long-term care, and certain surgical services, private and community hospitals which stepped up to cover the care gaps created after the various hospital closures have been operating at a deficit under existing apparently inflexible State and Federal financing system, physician and other staff shortages, coupled with ongoing funding obstacle for these providers impede further expansion of health care options. A budding community health center system which I believe has great promise and maybe can even transform access to and the quality of health care, not only in New Orleans but around the country is one of the bright, shining spots I see.

Failure so far to shore up the system raises a risk of a disintegration of the graduate medical education system in New Orleans, historically the source of most of the State's nurses and physicians. And meanwhile, hospitals and other health providers, local, State, and Federal health officials appear to be at an impasse over both short- and long-term plans for the region at this critical juncture.

Obviously those of us on this subcommittee do not have the answers. Hopefully listening to your testimony we can come up with some short-term solutions to maximize the opportunity for a great health care delivery system in the New Orleans area.

And as Chairman Stupak said, the only purpose of this hearing is to try to come up with some short-term answers to get the train back on the track for lack of a better term.

So I want to thank all of you for being here. We look forward to your testimony, and we look forward to working with you to help solve the significant obstacles that still stand in your path.

I yield back the balance of my time.

Mr. STUPAK. I thank the ranking member. Next, Ms. DeGette from Colorado, 5 minutes for opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much Mr. Chairman, and thank you in the whole committee for the continuing efforts to keep this issue of Hurricane Katrina on top of our agenda.

While the hurricane now was a year-and-a-half ago and while the country poured out its heart to those affected by the storm right after it was hit, attention has now been diverted to other issues. But for this committee and for the sake of those committed to rebuilding New Orleans the way it was, we have a duty to continue to engage on this issue.

I have been down to New Orleans twice looking at health care issues. In January 2006, this subcommittee looked at the damage put to the health care infrastructure of the city of New Orleans. Put simply, and as we saw from some of the slides, the media did not do it justice. The interior of Charity Hospital, which was once the keystone of the city's health care safety net, was completely destroyed. Medical records were rotting, mold was growing on the wall, medical equipment was strewn everywhere, and I can honestly say I have never seen anything like it.

During our field hearing the next day, I was gratified to hear about the efforts of some of the city's private hospitals to provide care to those who would otherwise seek aid at Charity. These hospitals, having suffered less damage and having insurance, were able to return to service much more quickly, and they stepped up to fill a need. The next time after that I was in New Orleans, I found that these hospitals were still fulfilling the need; but as that turned out, of course, the role these hospitals played was only temporary.

During the first hearing, I asked the panel of the private hospitals if their long-term business plans included providing care to the population previously served by Charity; and everybody got a look of shock on their face and said, no, that was not in their business plan for assuming the care of Charity's patients in the long term.

So Mr. Chairman, as we examine plans for the longer-term revitalization of the health care infrastructure of New Orleans, I look forward to hearing from our witnesses about putting in place a health care system that is permanently going to provide for health care for indigent patients. And frankly, while we are looking at long-term plans for New Orleans, we can't overlook those who are in need of health care services right now. Right now we have a patchwork and we have in our notebooks—and I know there is a map over there of the ad hoc system that has grown up in New Orleans. We need a thoughtful, long-term approach to deal with this. Otherwise, there will be nobody in place in 10 years to serve once the grand redesign has been put into place.

Now, frankly, the city faces the chicken and egg problem because medical professionals are needed in the community to provide care to those rebuilding the city while those medical professionals need a place to live and get paid for the services they are providing.

I want to hear from our witnesses today about how we might encourage physicians and nurses to return to the city and provide health services as they once did. Otherwise, the best reimbursement system will fail.

After Hurricane Katrina hit New Orleans, the response from the Federal, State, and local governments was at best an uncoordinated mess. Public servants from all levels of government worked courageously to meet health care needs of thousands throughout the city. But policymakers failed to maximize resources to address the immediate needs of patients and did not plan for how to bring the health care system back on line quickly. Instead of fixing the problem now, we more often see our elected officials and appointees squabbling.

And so as the chairman said, the time has come for all of us to put aside our differences, roll up our sleeves, and develop some consensus solutions. The people of New Orleans have suffered greatly, and it is our job to make their lives better.

One thing I just want to mention, I am deeply concerned and have been all along about what we do about establishing a long-term level one trauma center in New Orleans because the last few times I was down there they didn't have one. Now we have one operating, but as I understand it has only 100 beds. This will not suffice for the long-term future, and we are going to need to grapple with how we come up with a cohesive health care system in New Orleans that serves all the patients that need to be served in a rapid and technologically advanced way.

So I hope our witnesses have some ideas on this. I want to thank you again, Mr. Chairman, for holding this next in a continuing series of hearings, and I yield back.

Mr. STUPAK. I thank the gentlewoman. Next turn to Mr. Barton, ranking member of the committee. Mr. Barton, I appreciate your continued interest in oversight investigations. I know you were a chair a one time, and I certainly appreciate your continued interest.

Mr. BARTON. Thank you. Thank you, Mr. Chairman. I will submit a written statement. For the record, we support this hearing. We had a field hearing on this issue in New Orleans in the last Congress. We plan to continue to work on a bipartisan basis.

I will say I think you have set a record for most witnesses at one oversight hearing. We have 17 and I believe that beats the record of the last Congress, but we will get to the bottom of it.

I yield back.

[The prepared statement of Mr. Barton follows:]

Opening Statement of the Honorable Joe Barton

Ranking Member, Committee on Energy and Commerce

**Subcommittee on Oversight and Investigations Hearing on
Post-Katrina Health Care: Continuing Concerns and
Immediate Needs in the New Orleans Region**

March 13, 2007

Thank you Chairman Stupak. I would like to note at the outset that I very much support the Committee's continued, bipartisan work overseeing the response and recovery in the New Orleans region. I note that last year the subcommittee held a field hearing in New Orleans on related issues.

The hearing this morning on the immediate post-Katrina health care needs of the region will provide a solid start to what I hope is continued bipartisan oversight of, and solutions to, the health care issues in New Orleans and throughout the Gulf Coast areas that continue to suffer the consequences of the Katrina disaster.

The health care recovery needs to be accelerated, especially for all the people living and moving back to the New Orleans region.

It is clear that many of the problems faced by New Orleans and Louisiana can only be solved by the stakeholders there. These problems have been

made more challenging by Louisiana's unique and complicated health care financing system, which existed pre-Katrina.

The federal government and Congress can and should play a critical role, perhaps a leadership role, but we have to recognize that everybody has a role.

Many of the witnesses who will testify before us today have worked long and hard on restoring and improving the health care delivery system in New Orleans and Louisiana. Although there have been disagreements, misunderstandings, changed perceptions of what is needed or not needed, I hope that our discussions today can highlight ways to find solutions.

Fortunately, this oversight and investigations subcommittee has a powerful light that can cut through the fog of bureaucracy and competing interests. I think this is a worthy task, Chairman Stupak. I believe if we can accurately identify problems and prompt clear and frank discussion, we can break any impasse.

Of course, we will be especially watchful of the health care financing and public health systems that fall within the Committee's jurisdiction.

I welcome the witnesses. Let me express special appreciation for those of you working every day on the front lines at the community health clinics. You set powerful examples for us all.

Thank you, Mr. Chairman. I yield back the remainder of my time.

Mr. STUPAK. It was not the number of witnesses, it is the number of problems we are facing.

Next we will go to Mr. Melancon from Louisiana.

Mr. MELANCON. Thank you, Mr. Chairman. If I could, I would like to request by unanimous consent a statement from Congressman Jefferson and one from Louisiana Recovery Authority be added into the record?

Mr. STUPAK. Without objection it will be added.

Mr. MELANCON. Thank you, sir.

[The prepared statement of Mr. Jefferson follows:]

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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

**Statement of Congressman William J. Jefferson
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
March 13, 2007 at 9:30 a.m.**

Mr. Chairman and Members of the Committee:

Thank you, Mr Chairman for inviting me to present my remarks on this important matter. I wish to express my gratitude to the committee for its continued interest in rebuilding Louisiana's healthcare system in the New Orleans region. I also would like to take this opportunity to thank my colleague from Louisiana, Congressman Melancon, for his special commitment and dedication to the wellness of the people of Louisiana.

The matter before us is of vital importance. New Orleans public health conditions post-Katrina are affected by a combination of factors. Our overall economy is extremely weak and in a challenging recovery. The rebuilding process is low. The unemployment rate is high. Extreme poverty, poor access to healthcare services for uninsured and underserved communities, a health care professional shortage, and a lack of infrastructure add to the problems.

The communities that are the most affected by Hurricane Katrina had a poor health care infrastructure and some of the highest poverty rates in the nation before the storms reached the coast. For example, pre-Katrina Louisiana had the fourth highest uninsurance rate in the nation. Nearly one in four residents was living in poverty. Today, the number of people from the Gulf Coast who are uninsured and lack access to adequate health care has significantly increased.

Numerous studies show that poverty has a direct impact on the health, health care, and well being of all people. Other factors that exacerbate health disparities include low educational attainment, the absence of culturally and linguistically competent care, and lack of access to housing, needed health care services and treatments, and health care information.

As of October 2006, New Orleans is now home to 187,525 people, well under the pre-Katrina population of 484,674. But the health care resources necessary to adequately serve that level of population has not returned: only half of the previous 4,000 hospital beds are available; there are 34 nursing homes, down from 63; and 19 clinics, down from 90.

According to recent statements in the "New England Journal of Medicine", the health care situation in New Orleans area remains unacceptably primitive. The absence of chronic care facilities contribute to the lengthening of stay in acute care hospitals whose

cost exceed Centers for Medicare & Medicaid Services reimbursement, and these additional uncompensated expenses may soon force recently reopened hospital beds to close again. Without rapid, coordinated, and effective help from government agencies, it is feared that disproportionate human suffering and death will continue to plague greater New Orleans.

According to the Bureau of Health Professions, National Center for Health Workforce Analysis, the Louisiana health care systems before Hurricane Katrina and Rita was struggling with a shortage of primary care areas in 35 parishes and shortage of physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, and social workers. In the storm aftermaths, 7,500 health care professionals have been lost. Health care profession students were forced to evacuate the city and many relocated to Houston and Galveston in Texas. When Rita hit land near the Louisiana-Texas border, many of the 5,000 medical students and doctors training in Texas were evacuated again.

Prior to the Hurricanes Katrina and Rita, Louisiana had the highest cost of health care in the nation, but was rated the least healthiest State with the second highest mortality rate, the highest rate of premature deaths, and the third highest uninsured rate.

After Hurricane Katrina and Rita, Louisiana lost vast amounts of medical services (preventives, primary care, acute, emergency, critical care, surgical, subspecialty, maternity, gynecologic, family planning, sexually transmitted disease treatment, psychiatric/mental health, rehabilitation, administrative, diagnostic imaging, and laboratory)

In New Orleans, more than 2 in 3 displaced providers (4,486) were in three parishes around New Orleans--- Plaquemines, St Bernard, and Jefferson parishes--- most of whom were evacuated. Additionally, it is estimated that more than one in three health professionals in these parishes were primary care physicians. The Medical Center of Louisiana at New Orleans was the only Level 1 trauma center in the region and included Charity and Ochsner Hospitals. Prior to the opening of a new trauma 1 center at University Hospital less than 2 weeks ago, the next closest official level 1 trauma center was located at the Louisiana State University Medical Center in Shreveport, a 4 to 5 hours drive from New Orleans.

The number of staffed hospital beds in the City of New Orleans is about 60 percent less than before the tragedy. Prior to Katrina, 90 clinics run by the Medical Center of Louisiana at New Orleans (MCLNO) with the remainder being federally qualified health centers, mental health or addictive disorder clinics, or other specialty clinics. Post – hurricane, 19 clinics are open and generally operating in less than 50 percent or pre – Katrina capacity. More than three-fourths of the safety net clinics remain closed, and many of those that were open have limited capacity. More than 50 percent of inpatient care provider in MCLNO was provided to uninsured patients and more than 8 in 10 (85 percent) patients had annual incomes that were \$20,000 or less.

In order to rebuild the greater New Orleans Areas, it is critical that we rebuild substantial parts of Charity system as a comprehensive Public and teaching hospital because compared to most cities, New Orleans had a larger percentage of poor and unhealthy residents, fewer resident with private health insurance coverage, and fewer financial resources to meet the health needs of its citizens.

We should create a public –private partnership aiming to maintain the service mission of the public hospital while also attracting a mix of patients that would enhance financial stability, allow the private sector to participate in the provision of safety net options and fill Medical Education needs. We must incentivize the return of healthcare professionals in the area, rebuild our health care infrastructure, rebuild pipelines of providers in medically needy and underserved community, and strengthen Public Health protections for future major disasters and emergency situations.

Thank you

OPENING STATEMENT OF HON. CHARLIE MELANCON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. MELANCON. First, I would like to welcome all witnesses today and thank them for the time they have taken to come to testify. I would also like to thank you, Mr. Chairman, for dedicating the committee's time and the resources to the Gulf Coast health care crisis.

I am glad to see Congress take another step towards living up to its commitments that we have made in August 2006 on the Katrina-Rita Task Force Trip to the Gulf Coast.

A year-and-a-half has passed since Hurricane Katrina made landfall, and south Louisiana's health care system remains in crisis. There is no doubt that our health care system faces serious long-term challenges, but today we are here to focus our attention on the immediate needs. Our objectives are simple. We want to help enhance the region's capacity to take care of the patients' immediate needs and want to help the region demonstrate a level of care and quality that will bring our people back.

Achieving these objectives requires us to understand what resources are needed. Today's testimony will help the committee to grasp and meet those needs. To explain the situation in detail is outside the scope of this opening statement, but just to give you some examples, our primary caregivers are few and far between, hospitals are filled to capacity with many who have not received basic primary care in over a year, the number of uninsured has hit an all-time high. In a recent Times-Picayune article, the average wait time in the emergency room at Touro Infirmary was 6 to 8 hours. That is about the same time it takes to drive from New Orleans to Houston or Atlanta. In Chalmette, Louisiana, there isn't even a hospital to wait in; rather people line up outside tents in front of the Wal-Mart or what used to be the Wal-Mart to receive health care services that are still being provided.

I hope that today's hearings help us identify our short-term challenges. I also want to use this opportunity for all stakeholders in the region to sit down together and talk with each other, rather than at each other. I want to remain focused on finding common ground. Everyone in this room has been called to serve the people, either through medicine or public service. We should remain focused on the common ground of serving the people as we continue our conversations over the next several months.

I want to again thank the witnesses who have come here today, and thank you for your continued and dedicated service in providing good health care to the people of the disaster-ridden area. And again, I would like to thank Chairman Stupak for his persistence and his tenacity. He has given me assurance that this subcommittee will revisit the Gulf Coast health care crisis as many times as it may be needed until we find solutions.

I look forward to working with you to resolve the important issues and get our health care system back running in a way that it should be.

Thank you, Mr. Chairman. I yield back for time.

Mr. STUPAK. I thank the gentleman. Up next, Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman. I just wanted to welcome our witnesses. I don't have an opening statement this morning. I look forward to hearing from them, and I yield back.

Mr. STUPAK. Mr. Green from Texas, opening statement?

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. I would like to have my full statement placed into the record and just briefly say that it continues to shock us. I have a district in Houston, and knowing what our neighbors in Louisiana and New Orleans have gone through and to see that the status of the health care where there are no public hospitals and the number of people who have a disproportionate share of the private, for-profit hospitals weren't picking it up, obviously there has to be a lot of changes in it. And Mr. Chairman, I am glad we are having this hearing, and hopefully we will follow up with legislation. I serve on the Health Subcommittee, so I would like to see how we could deal with it. On a personal note, in Houston after Katrina or during Katrina, we received over 100,000 Katrina evacuees, in fact, estimates up to 250,000; and I was so proud of what our community did on very short notice, the for-profit hospitals, non-profit, plus our public hospitals coming together and working side by side when the rest of the year they compete every day but it worked.

I have to admit, Mr. Chairman, we got some commitments from the Federal Government because Texas is not known as a high expense Medicaid State. In fact, our match is much more than what Louisiana was. We did get Federalized the State/local match. The problem is there were lots of commitments made on that Labor Day of 2005 but it didn't work out. It is frustrating.

And so I hope our Oversight Committee can bring to life what we need to do, plus look at legislative solutions so when this happens again, because this year it could be Houston where we may be going to New Orleans, in all honesty. I hope that is not the case, but looking at your infrastructure, we still have to build a lot there.

But there but for the grace of God goes any of us who live along the Gulf Coast or the east coast of the United States, so I am glad you are having this oversight. Thank you.

Mr. STUPAK. Thank you, Mr. Green.

Next I go to Mr. Burgess from Texas. Mr. Burgess, opening statement?

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. Again, I thank you for calling this hearing today.

We have all read a lot about what happened down in the Gulf Coast. We all have questions about preparedness, we all have questions about the adequacy of the response. Most explosive have been the issues surrounding the three catastrophic events that occurred the day that Katrina hit the Gulf Coast. We had the wind damage, you had damage from the surge down in Plaquemines and Port Chalmette, and then the levee breach that affected both West Jefferson and the city of New Orleans itself.

Responsibility rests at every level of government. The time has certainly passed for fixing blame; but today in this room, in this committee we must focus on not only what destroyed the health care community, the extent to which it has recovered and can recover in the future, and how to prevent this from ever happening again.

In October 2005 I visited both Orleans and Jefferson Parishes. The people there were very kind to me and welcome me into their community. It wasn't really an official visit, but I wanted to see for myself the physical damage to the buildings and the property; and most important to me is what was happening in the level of the local practitioner in the health care community.

Let me put my opening statement into three principles, the most important is having a plan in place in case a disaster threatens. The case in point, I think the gentle lady from Colorado already addressed, the difference between HCA's hospital implementation of an emergency plan and essentially the lack of a plan across the street at Charity Hospital. Across the street from each other the differences and outcome were astronomical. One stands today, and today as we sit here in this committee we wonder if one of the venerable old institutions in medicine will ever be what it once was again, Charity Hospital.

[Slide shown.]

There is a slide up there. Actually, this is the correct slide. The obvious need for electronic medical records. It is amazing how a small electronic device can keep health records of thousands of individuals safe from destruction.

[Slide shown.]

This is a photograph from our visit, our field hearing last January to Charity Hospital. This is the records room; and as you can see because of the extent of the mold damage and water damage to those records, very little useful data will be able to be gleaned about anyone's ongoing medical care.

This committee has the oversight capabilities to encourage and set regulations to move the use of medical records along, and I believe we should.

And just parenthetically, Mr. Chairman, I will add that yesterday I was at Walter Reed Hospital here in Washington and the same issue came up. We all heard the great things the Veterans Administration is doing with their electronic medical records, but apparently the DOD medical records don't communicate with the VA medical records and that remains a problem for our soldiers who are on medical hold or are looking to get out of the military for medical reasons.

Just after Katrina passed, many displaced individuals, thousands with severe medical illnesses were uprooted and moved to various places, some to my district in Texas. The Tarrant County Resource Connection in Ft. Worth where one of my district offices is located was a recipient for some people who had to leave New Orleans. We worked with the local American Red Cross to prepare for the busloads of citizens to arrive. When they did arrive, many were in quite fragile medical condition. You can imagine my concern when I got a call from a staff member who asked me if a lady had a C-section, how soon could she sleep on the floor. Why do we need to

know this? Well, we have a lady here who had a C-section yesterday, and we don't have enough cots for her. The really bad part of that story was at the time, no one had any idea to the hospital to which her baby was evacuated. It took us several days to ascertain that.

The medical community in north Texas did rise to the occasion both in Tarrant, Denton, and Dallas Counties and did a wonderful job with helping people; but the fact is, it should never have been necessary for them to respond in such an emergent fashion.

The final principle is that I want to discuss in this hearing is actually set out a plan of action. We are focusing on the achievable and the desirable. We have a tendency in Congress to simply debate problems forever, but this hearing needs to be about solutions and the follow-through. Specifically it was well-documented that after Katrina the medical community in New Orleans was not recovering, the medical professionals were unable to care for individuals, they lacked funding and resources to actually assist those in need. The disaster medical assistance teams flown in from around the country did a great job. The reality was if they hadn't been there to set up on the grounds of some of the hospitals, the waits for emergency treatment were in excess of 24 hours, sometimes for something as minor as an ankle sprain or as major as a heart attack. Any major disaster, a bus crash or fire that might affect five or more people, would greatly benefit from a level one trauma center; and New Orleans lost their trauma center. Now that means if a bus crash occurs, the lives of many more could be jeopardized where they would have to go over 2 hours to the nearest trauma center.

The effects are ongoing, Mr. Chairman. We cannot continue to just debate and point fingers. This committee must make specific goals to instigate change. We must also accept responsibility to continue our oversight. I would recommend quarterly hearings on this subject and at least once a year in the city of New Orleans itself.

As we begin today's hearing, I am hopeful that we will all keep in mind that this is about helping to mitigate future disasters and ensuring that the best health care is available to those in the greatest need, even in the gravest of times.

Thank you, Mr. Chairman. I will yield back.

Mr. STUPAK. I said earlier we have about three or four hearings this week in committee, that you are overworking us and underpaying us. But I see you are here with us today. Thanks for coming.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

The CHAIRMAN. Mr. Chairman, you are most gracious. I want to commend you for the outstanding job you are doing and also to thank you for holding a very important hearing here today. I want to acknowledge also the contributions and hard work on this hearing made by the distinguished ranking member of this subcommittee, Mr. Whitfield, as well as that of our friend and colleague, the ranking member of the full committee, Mr. Barton.

Nearly 18 months after Hurricane Katrina, major problems remain on how to care for the region's many residents who are trying to rebuild their lives or return to their homes. I fear we are now on the verge of turning the Nation's largest natural disaster into the Nation's largest man-made disaster. Private hospitals are bleeding red ink. There is still no agreement on how to or even if to rebuild Big Charity, the Nation's primary public hospital.

The Department of Veterans Affairs has proposed to collaborate with that effort, but now there is disagreement as to what role they should play and where the new VA hospital should be located or even if they should remain a partner in the deal with Charity.

If no one draws a line through the center of the city, it reveals that there is no functioning hospital which exists east of that line. Chalmette, east New Orleans, St. Bernard Parish, all remain without a medical facility. Residents there rely on a few small overworked and overwhelmed clinics where there are health care needs. Many nursing homes remain closed. There is acute shortage of nurses for the entire area. There are virtually no beds in the region for those needing detox treatment. Caring for the mentally ill remains exceptionally challenging as many psychiatrists and other mental health specialists have left the region. And at best, there are few beds to house such patients.

Those doctors who are trying to remain in the region often encounter difficulty in obtaining reimbursements for services to either patients or hospitals. Many have already left but others may be soon forced to do likewise because they cannot afford to remain there because of financial problems.

The situation here then is bleak. It is therefore to the third panel, the government panel, that I will direct the rest of my statement.

Without a doubt you have all put significant energy into trying to solve these problems. Your efforts are appreciated, especially for the untold hours that you have dedicated to this cause. Nevertheless, it is clear that things are not working. Let me provide an example.

Secretary Leavitt asked the State of Louisiana to provide a plan on how to rebuild the Nation's health care infrastructure. Though much of the disagreement was encountered, the difficult decisions were presented and made. The State and its various stakeholders, public and private, held up their side of the bargain and they produced a plan.

That plan, known as the Collaborative, was transmitted by the Governor of Louisiana to Secretary Leavitt on October 20, 2006, about 6 months ago. The State's plan called for a series of pilot projects in region 1 where the devastated parishes are located in and around New Orleans. What Secretary Leavitt sent back is not even a formal plan. It is a loose confederation of spreadsheets and bullet points. It asks the State to disassemble its statewide public hospital system and replace it with some form of insurance program, a most curious consequence.

There are almost no specifics in the plan, and at least none are available to the public. There is not even a formal publication from the Secretary to the Louisiana Governor that this committee could review, despite the requests of this committee to obtain such a doc-

ument; and we will again, at the appropriate time, ask the Secretary to make such document available to the committee. The State of Louisiana now counters that the HHS proposal will not work.

Now, I do not bring these points up to point fingers but to suggest that we are now facing a deadlock between two very important players who are needed to solve these problems. If not fixed quickly, the next 6 months will be spent on dueling spreadsheets. Simply put, the plan proposed by Secretary Leavitt, regardless of your opinion of the State's system, is simply too large of a task to undertake at this time. Even if adopted, it will not address the immediate problems faced by patients and the practitioners in this region.

I therefore call on the Secretary of Health and Human Services and the Louisiana Secretary of Health and Hospitals to immediately convene a series of meetings to re-energize the next steps on how to move forward. Both are at an impasse and a serious one at that. If not corrected, this situation will jeopardize not only progress that has been made on the ground but also the future of the region, and I would note that this committee will be having further hearings to bring the Secretary and others before us to explain what they are doing and whether progress has been made as a result of these hearings today.

Mr. Chairman, I want to congratulate you and commend you for what you have done today. I suggest that you consider holding the additional hearings that are needed on this matter. I believe the committee can and should work with and hold accountable if necessary the public entities that are responsible for providing leadership in this important area.

Thank you, Mr. Chairman, I appreciate your courtesy.

Mr. STUPAK. I thank the gentleman.

Mr. WHITFIELD. Mr. Chairman?

Mr. STUPAK. Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, Congresswoman Blackburn officially became a member of the Energy and Commerce Committee last night, and she will be a member of the Oversight and Investigation Subcommittee but will not be a member until Thursday. And she is very much interested in the topic of this hearing today, so I ask your unanimous consent that she be allowed to participate in this hearing today.

Mr. STUPAK. Hearing no objections, that will be granted. Mrs. Blackburn will be allowed to participate in this hearing. She was actually with us in New Orleans a year ago when we had the hearing, so it is good to have her back.

Earlier today Mr. Melancon asked me to put two statements in the record. Congressman William J. Jefferson, he is a Member from the New Orleans area. We will accept that statement. The other statement, though, on behalf of Louisiana Recovery Authority we cannot accept. This is oversight investigations. It would not be subject to any kind of cross-examination or any type of questioning from this panel, and each group that wants to put in a statement we cannot accept. It would just clutter the record. We want to keep ours clear.

If the gentleman wishes to refer to it throughout or if any Member wishes to see it to refer to it throughout this hearing today to ask a question to a witness, to pose a question from it, we will accept it for that purpose only.

With that, we have our first panel up. I ask the panel—this is an Oversight Investigation Committee as I indicated. It is tradition here that we swear the witnesses.

[Witnesses sworn.]

The record should reflect all witnesses indicated positive that they understand they are under oath. They are now under oath. We will begin with our first opening statement by Ms. Rowland, recognized for 5 minutes for your opening statement.

STATEMENT OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION, EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, WASHINGTON, DC

Ms. ROWLAND. Mr. Chairman, members of the subcommittee, I am honored to participate today in this important hearing to assess the state of health care services in New Orleans 18 months after Katrina and hope to help frame some of the issues before you today.

Louisiana, we need to recall, before Katrina was one of the poorest States in the Nation with over a quarter of its residents living in poverty. It ranked at the bottom of most health statistics in terms of the States of the Union with higher rates of diabetes, heart disease, AIDS, infant mortality. It had limited public and private coverage, leaving one in five of its residents uninsured. But clearly, this was a State with severe health care needs. It provided for those needs through a two-tier system, private doctors and hospitals for the insured and a State-run charity hospital system for the poor and uninsured, financed largely through Medicaid disproportionate share hospital payments.

That made care in New Orleans for the poor and the uninsured hospital-centered and based and Charity the source of most of the inpatient services, psychiatric services, specialty care for the low-income population. Katrina and the flooding that subsequently happened destroyed the infrastructure as well as the structure for care of the uninsured in New Orleans. You have all gone through the very many hospitals that had to close, the loss of the workforce.

We have been doing survey work in New Orleans trying to understand what the needs of the health care population there are, and in October 2006 our household interview survey in the New Orleans area revealed continued high rates of uninsurance, problems with access to care, and the fact that 90 percent of our respondents did not feel there were enough services, hospitals, clinics, medical facilities in the New Orleans area to meet their needs and that it was one of the most troubling factors in their decision of whether to return to New Orleans or to stay in New Orleans.

There are severe challenges to the workforce shortages and the limited hospital and clinic financing, critical shortages of mental health services, and psychiatric beds with the closure of Charity. There is a growing uninsured population, both as people have lost their job base coverage but also with the new labor force coming

into the city. And there has been delayed assistance from the Federal Government to support community-based care and troubling negotiations that continue over how to rebuild the system.

There are steps, however, that could be taken now to help restore some of the services to the Louisiana area and to improve access to care and give residents the confidence they need to have their health services available.

First and foremost is to maintain the Medicaid and LaSCHIP coverage, the SCHIP program for children in Louisiana, and hopefully in your reauthorization of SCHIP, to continue to provide the funds there so that the children of Louisiana can get their care. But more importantly, immediately you can raise the eligibility levels or the State can move to do that, to provide Medicaid assistance to more of the low-income adults who currently don't qualify for Medicaid because the income eligibility level remains set at 20 percent of the Federal poverty level, or \$3,000 a year.

Second, you need to rebuild the capacity in the city. Health care coverage can help that by putting the dollars into the providers from the patients as they seek care, but additional incentive payments are needed to recruit back a workforce; and you can also look at provisions in the Medicare statute that would extend the reimbursement for extraordinary labor costs that can come through the Medicare program to help improve the financing for the hospital system.

But most importantly as I am sure this panel will tell you, you need to develop secure financing for the emerging development of community-based care that can help move the care out to where the patients are and can help to provide early access to primary and preventative services that can deal with the chronic illnesses that face so many of the individuals in New Orleans.

So in sum, I think you need to really look at how to put services in place, and financing is a very important piece of that. There needs to be greater flexibility over the use of the already-allocated DSH funds, more direct Federal assistance through the use of the discretionary fund that remain uncommitted from the Deficit Reduction Act, help build access to care and to support some of the community development. The Social Services Block Grant that has been so critical to extending psychiatric services is about to run out. It could be extended to provide additional resources there to help rebuild the capacity to deliver mental health services, and you may well need to look at supplemental appropriations to provide more of the on-the-ground services that are required.

As your panelists will tell you today, the needs are real, the commitment to provide services is extraordinary among those who have been working in the trenches for so many months to help restore coverage, but the resources are not there on the ground to let them do the job they need to do.

I hope that this hearing will help move us forward to address those deficits and to give the people of New Orleans the health care services they need and deserve.

Thank you very much, and I will welcome your questions.

[The prepared statement of Ms. Rowland appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Ms. Rowland. Mr. Thomas Koehl, director, Operation Blessing Disaster Relief Medical Center. Sir, for 5 minutes you are recognized.

Mr. KOEHL. Thank you. I would like to show a video first.

Mr. STUPAK. Sure.

[Video shown.]

STATEMENT OF THOMAS KOEHL, DIRECTOR, OPERATION BLESSING DISASTER

Mr. KOEHL. My name is Thomas Koehl. I work for Operation Blessing, a humanitarian relief organization that responds to both domestic and international disasters.

Among other activities, as you have seen, we provide a free medical/dental clinic in New Orleans. We presently see 75 to 100 patients a day with a staff of volunteer doctors, nurses, nurse practitioners, and physicians assistants.

In the past 11 months we have provided health care for 15,000 patients and provided over 25,000 free prescriptions to these residents of the stricken city.

These residents were pulled from the rooftops, they waded in water, they spent days sweltering in the heat on highway overpasses and in the Superdome. They are a never-before-seen American. Over 100,000 newly made poor, helpless, homeless, and marginalized. Our task, should we not forget it, yours and mine, is to relieve their suffering.

When Katrina struck, it washed away their homes, their jobs, and their health care but did not wash away their high blood pressure, their diabetes, or their other chronic illnesses.

The need for health care is so great that at our clinic every weekday morning at 3:00 to 4:00 in the morning the line begins. Grandmothers, single mothers with sick children, entire families waiting in the cold and waiting in the dark for a health care provider.

The need was so great that as you saw on our video, Operation Blessing recently partnered with Remote Area Medical, International Medical Alliance, the New Orleans Health Department, and the Louisiana Department of Health and Hospitals to host this medical recovery week.

On the very first morning of this event, I met a man named Mike in our triage area. He had made his way through the maze of tents concentrating on staying warm and keeping his place in line. He was one of hundreds who had arrived in the pre-dawn hours. I asked Mike when he had arrived. He had gotten in line at 10 p.m. the night before. I asked him why he was there, and he said, I am a diabetic and I am out of insulin. I have been out for months, and I can't find anyone who can help me.

Like thousands of others returning as evacuees from the hurricane, Mike had returned to a city where health care was limited and the majority of residents are now uninsured. On this day, he along with 600 other patients received free medical care.

We brought in more than 400 doctors, dentists, and nurses from across the country with a total of 891 volunteers to provide 9,000 medical services to more than 3,000 patients by week end. These services included dental work, eye exams, free glasses, primary

health care, OB/GYN services, diabetic care, pediatric, and cardiology care.

To accommodate the influx of patients, we set up 20,000 square feet of tent space to serve as additional exam rooms.

This is simply a larger version of what we do every day in New Orleans. For Mike, help was as simple as giving him one blood glucose meter to test his blood sugar and a vial of insulin. This is what he needed to survive, was a little bottle of insulin and he couldn't get anyone to help him.

Our patients still, 18 months after Katrina, get in line before daylight every day. Over 50 percent have high blood pressure. 30 percent of those with high blood pressure come to our door in crisis with blood pressure so high they cannot be managed. 26 percent of our patients are diabetic. Many walk through the door daily with blood sugar so high they cannot be measured by the instruments that we have. Two to three patients per week come through the door and have not had their insulin since Katrina. They just heard about us and just showed up at our door because no one would help them. Patients are turned away from the free clinics and turned away from the hospitals because they are at capacity every day.

These citizens are not what you classically think of when you think of indigent patients. These citizens, just 18 months ago, owned their own homes, worked full time, went to their children's band performances and volunteered in their community. They were just like you and your neighbors, people you would invite over to your home for dinner.

Would you feel comfortable if your neighbors had to stand in line all night in the cold to see a doctor? Or would you feel comfortable if they had to be sent to a hospital in an ambulance where they were told they had to wait in the ambulance 4 to 5 hours before being admitted into the emergency room because the emergency room was so overcrowded? The question then is who is your neighbor? Who is my neighbor? Is it just the family whose grass meets ours or should we be concerned about those Americans we have not yet met?

This population is our modern-day Job. They have lost their loved ones, their homes, their cars, their jobs, and their insurance. According to the local newspaper, we now have 127,000 uninsured residents in greater New Orleans. They see others profiting from a disaster in which they lost everything, including their faith in a system which had promised them health care, insurance, pensions, and most importantly, protection.

The video said that Dr. Steven's office in New Orleans has stated that the death rate is 48 percent higher per capita now than it was before Katrina. The infant mortality rate is five times higher now than before Katrina. And the level of depression is present now in rates never before seen in the United States. This depression and stress act to worsen and exacerbate the individual health care issues and disease process.

We are here to discuss what needs to be done going forward. I would ask you to build a system where it is easier for non-profit agencies to operate in the disaster-stricken area. Operation Blessing can provide its own infrastructure but many non-profits cannot. Please build a system where they can operate.

Create a system where doctors and nurses that pass national boards and exams are allowed to come and practice in a State that is under a disaster notice. Last week, the State of Louisiana Board of Nursing declared they would no longer allow volunteer nurses from other States to come in and work. They said they did not need them.

Again, our patients get in line at 3:00 and 4:00 in the morning. We turn away 75 patients a day when we see 100 patients a day, and the State of Louisiana Board of Nursing says we are not going to let any more volunteer nurses come in. They need your oversight.

Build a system that encourages for-profit providers to return to a region where the dollars follow the patient, where the uninsured have choices and can seek care and private health care facilities and those doctors and offices and hospitals are reimbursed for that care.

Among the recommendations being considered to improve primary and preventative care are technology initiatives to track the person's medical history and to create community health care clinics. These community clinics would refer patients to specialists, manage disease care, and provide a consistent system for tracking care.

And please remember that everything that was needed by the New Orleans is also needed by the health care system you seek to rebuild. Infrastructure such as housing, schools for doctors' and nurses' children, utilities, and people with the economic ability to pay for these services that are being offered. All of these are necessary for a sustainable health care system.

To close, I would like to state that Operation Blessing has provided free medical and dental services to more than 15,000 patients. We have spent \$1.5 million. But because we are able to work with volunteers, we have delivered \$11 to \$12 million worth of medical services to these patients. We could only do this by partnering with other agencies and collaborative efforts with our volunteers and donors.

We would like to thank all those who have made this possible. We are grateful for the opportunity to serve the residents of New Orleans and to serve the United States of America. Thank you.

[The prepared statement of Dr. Koehl appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Mr. Koehl.

Dr. Cathi Fontenot, medical director, Medical Center of Louisiana, New Orleans. Cathi, 5 minutes, please, if you would?

**STATEMENT OF CATHI FONTENOT, M.D., MEDICAL DIRECTOR,
MEDICAL CENTER OF LOUISIANA AT NEW ORLEANS**

Dr. FONTENOT. Good morning. I would first like to thank members of the subcommittee including Chairman Stupak and Ranking Member Whitfield and others on this committee who came down to visit with us and go through Charity Hospital a little over a year ago and actually since that time as well.

My name is Cathi Fontenot. I am the medical director of the Medical Center of Louisiana at New Orleans comprised of both Charity and University Hospitals. I would like to take this oppor-

tunity for a brief visit back to New Orleans during that week in August 2005. We have got a 2-minute video, and I promise I will keep to my 5 minutes.

[Video shown.]

The storm effectively destroyed both facilities, University at Charity Hospital. That loss has been devastating to the community. The current status of health care infrastructure in New Orleans is tenuous and critically ill. We have been able to temporarily reopen portions of University Hospital, restoring approximately 140 inpatient beds including the trauma center I might add; but sicker patients who in many cases have lost their health care providers present to our emergency rooms with uncontrolled disease processes due to lack of primary care and access to medications as you have already heard.

Cancer patients who present to our hospital with no health insurance have no choice but to travel 60 miles to a rural LSU Hospital for their chemo or radiation and back home while weak and miserable, and that is assuming they have transportation.

The status of behavioral health is even more dismal with limited outpatient and inpatient services in the greater New Orleans area. In our emergency room alone there are days when half of our emergency department beds are occupied by psychiatric patients because there are no inpatient beds available for them.

Solutions to the health care crisis in New Orleans are being developed with partners that you see here at this table but are constrained by availability of space and health care providers, both primary care and specialists. A critical component of the effort to restore health care services involves establishing and strengthening the network of neighborhood clinics that we refer to as PATH, the Partners to Access for Health Care for the Uninsured where we serve as the major hospital partner and provide hospital services as well as specialty access. It is only this sort of collaborative effort that can be a real opportunity to accomplish health care reform as we go forward in the New Orleans area.

The plan for the Medical Center includes the establishment of the community primary care clinics of our own also in temporary facilities so that primary care can be delivered in communities where the basic principles of prevention and disease management are best delivered. One of the major challenges for health care providers in the New Orleans region is the lack of access to specialty care, and we anticipate that at least to some degree we can maximize the use of the limited specialty care available by using telemedicine technology, becoming more efficient at directing patients to the right place for the right reason at the right time.

A shared electronic record is critical to such a network of providers, in order to share information, eliminate costly duplication of effort. We look forward to continuing our work with other safety net providers because such a coalition is crucial to real health care reform and necessary for institution of a new model of health care in the region, and we are proud to serve as a partner in that endeavor.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Fontenot appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you. Next we have Dr. Bryan Bertucci, coroner/family physician, St. Bernard Health Center, Chalmette, Louisiana. Doctor?

STATEMENT OF BRYAN BERTUCCI, M.D., CORONER/FAMILY PHYSICIAN, ST. BERNARD HEALTH CENTER

Dr. BERTUCCI. Good morning. God bless you and God bless America.

Disease and death know no party, and I am happy to say we are here for the patients' interests today; and I appreciate the opportunity to speak.

My name is Dr. Bryan Bertucci. I am a family practice physician and the coroner of St. Bernard Parish.

Medicine is not well in St. Bernard. One hundred percent of our homes, offices, and buildings were destroyed, and for the first time in history, FEMA declared a parish or country 100 percent destroyed. One hundred fifty-four St. Bernard residents died.

St. Bernard was flooded twice by Hurricanes Rita and Katrina, experienced an oil spill, liquid mud, mold, snakes, flies, mosquitoes, piles of trash, mice and rats. St. Bernard is a very difficult place to live, and despite that, our residents returned. You have to be tough to live in St. Bernard Parish.

Our biggest hindrance is the overwhelming lack of medical facilities. Our 194-bed hospital was destroyed. One hundred fifty physicians left, and now we only have six. We have 10 registered nurses.

I have some slides.

[Slide shown.]

This is of the office building where I practiced that housed 20 primary care doctors. We lost all those doctors. That had 13 feet of water. You can just go through the slides until we get to the clinic.

You are asking, what can we do? Well, first, you have already started by giving student loan deferments for the people coming out of medical school to help pay off their loans. That is No. 1. The biggest loss was young primary care doctors. That was our largest loss. We need to get those people back. Without the primary care, you are not going to get the specialist. Without the specialist, the hospitals can't support themselves.

Second, SBA loans. I still cannot get an SBA loan to rebuild my office, so I can't imagine what the other doctors are trying to do. We also need loans for people who weren't there before, low-interest loans to help them build their offices. You need to have increased recompensation for those doctors, and you need housing. The three doctors that are working in my office all live in trailers. We all lost our homes. We have no office space available for these people to come back.

The buildings that we lost, and I am sorry because we went through so fast, but all of those buildings are totally destroyed. We have no housing for our specialists.

Mr. STUPAK. We can go through them quick one more time if you would like?

Dr. BERTUCCI. Yes, if you would.

Mr. STUPAK. Go through the slides again, please.

Dr. BERTUCCI. Next?

[Slide shown.]

Yes, this is our neurologist's office.

Mr. STUPAK. Is that open now?

Dr. BERTUCCI. No. All of these were just taken 3 days ago.

Mr. STUPAK. OK.

[Slide shown.]

Dr. BERTUCCI. This is a pediatrics office.

[Slide shown.]

This is an ear, nose, and throat office.

[Slide shown.]

That is another ear, nose, and throat office. And this is actually rebuilt.

[Slide shown.]

This is one of our two clinics at work. This is a dialysis unit, and obviously you see the condition of the ground surrounding it; but we are rebuilding ourselves. We have an eye doctor, too.

[Slide shown.]

This is our pharmacy. We actually have six pharmacies back.

[Slides shown.]

And the next picture, this is our mental health trailer and this is the trailers that we work in.

Perhaps I think our biggest encounter and problem was getting funding back to rebuild our facilities. Chalmette Medical Center was a fee-for-service medical hospital; and as such, we were penalized for being privatized. We were told that we couldn't have any money from FEMA because we were a fee-for-service. The Community Disaster Loan didn't qualify because we weren't on the parish budget, so we were penalized for being independent. The Stafford Act obviously didn't allow doctors and nurses to get paid, and the Community Block Grant money, \$621 million went to the parish, medicine got none because we were fee-for-service.

Perhaps our biggest problem is that Federal and State officials do not realize that St. Bernard is not part of New Orleans Parish. Funds that go to Orleans Parish stay in Orleans Parish.

Medicine has metamorphosized itself from the DMAT teams which you saw pictures of, public health, to a 22,000 square foot trailer. We see 100 to 120 patients a day. The severity of the illnesses that we see are equivalent to a small emergency room or an urgent care center. We I&D abscesses, suture lacerations, stabilize MIs and congestive heart failure, and give IV fluids and IV antibiotics. Almost a quarter of these patients have no insurance and are no-pay or self-pay.

A foundation is willing to give us 30 acres of land to build a new hospital that is 8 feet higher than where Chalmette Medical Center was located. The Franciscans has offered us financial and professional help to try and make these dreams become a reality.

Mental health is in crisis. Fifty to 60 percent of the patients I see and 20 to 30 percent of the children I see are depressed. Drug overdose is a problem in our parish, and we have no substance abuse clinics or beds to put these people in; and the schizophrenics or psychotics due to lack of access to outpatient care have become a problem for our emergency rooms.

St. Bernard is lacking significant emergency room services and has to ship patients 18 to 35 miles to an emergency room. Our par-

ish is surrounded by water and our limited ambulances have to cross bridges, railroad tracks, and circumvent traffic jams. A routine emergency room visit takes 4 to 8 hours.

The logical solution for St. Bernard is a permanent physician office building, outpatient surgery center, outpatient diagnostic center, and eventually a hospital.

The medical village will assure primary care and specialty return. It will decrease the number of our residents who have to go out to emergency rooms and free up our ambulances and free up Orleans' emergency room beds. It will allow our elderly to return so that we can have nursing homes and we can have homes for assisted living. It will provide jobs as the hospital was one of the largest employers in our parish. It also had 24 psych beds so psych beds are a possibility. If you want electronic medical records and a medical home, we need primary care doctors, we need specialists who will support that concept, and we need a hospital as a safety net for the patients who can't be controlled as an outpatient.

We need three big things. We need the bridge money, Social Service Block Grant Money with an extension of the funds that are due to expire on July 31. We do have some allocated to us. We need that expanded.

We need to make more SSBG funds available to medicine for permanent structures or infrastructure. We need Community Block Grant Funds available to us now that we have a non-profit institution. We are not fee for services. We are a non-profit so that we can have permanent building structures. And we need most importantly a rural designation for our Medicaid and Medicaid patients to help offset the cost of treating indigent patients for hospitals and physicians. We need some help with the rural reimbursement.

What if your child had a problem and you knew what they needed? As a parent, what would you do? St. Bernard, America is your child. We need your help. We need brick and we need mortar. We need permanent physician office buildings and we need a hospital.

As the hospitals meet later today—

Mr. STUPAK. Doctor, please summarize.

Dr. BERTUCCI. I am going to finish. As the hospitals meet later today, leave an empty chair for St. Bernard. We had 240 hospital beds. Imagine the pain of our residents as they hear the justifiable cries for help from the other hospitals and while you call the name for St. Bernard, you hear just silence. We need a hospital. We need your help. Thank you for listening.

[The prepared statement of Dr. Bertucci appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you. Dr. Karen DeSalvo is executive director of Tulane University Community Health Center at Covenant House.

**STATEMENT OF KAREN DESALVO, M.D. EXECUTIVE DIRECTOR,
TULANE UNIVERSITY COMMUNITY HEALTH CENTER AT COVENANT HOUSE**

Dr. DESALVO. Good morning, Mr. Chairman and members of the subcommittee. Thank you all for having us here today. I just want to say it is really an honor to be on this panel with a lot of folks

that I have rolled up my sleeves and been working with in the past 18 months now, some of whom I didn't even know before the storm.

As you said, I am Karen DeSalvo. I am the executive director of the Tulane University Community Health Center at Covenant House which is a clinic formed in the aftermath of the storm to meet the urgent needs of our city's population.

Today I am going to share with you my perspective as a primary care physician caring for the uninsured patients in our city, and I want to give you a snapshot of what it is like to practice medicine in New Orleans including describing our successes and challenges and suggest what would help improve access to care immediately while we debate the larger policy issues.

We have come a long way in restoring care in our city despite the many struggles that we still have, and while much has been made of the divisions, an often overlooked bright spot has been the progress we have made in building a primary care network for our most vulnerable citizens.

The Tulane Community Health Center at Covenant House is an example of such a success. We started as a makeshift clinic. We were just a post-Katrina first aid station. It was only a card table and basic supplies. This was in early September 2005.

We have evolved into a prototype medical home and become a source of care for hundreds of patients and have seen over 12,000 of them since opening our doors. Our medical home is able to provide free care. It is basic primary care for adults. We are a multi-disciplinary team. The typical patient that we see is middle-aged, they are uninsured, and they have multiple chronic diseases.

To serve them we have begged, bartered, negotiated, access to basic laboratory and diagnostic studies. We are able to use a sophisticated electronic medical record to help us manage our populations and be as cost effective as possible. We are also filling a training void for health professionals with the added benefit of exposing the next generation of clinicians to a patient-centered model of primary care.

We are determined to keep our doors open to provide these critical services to those that otherwise have no alternatives, and we have received some Government support from SSBG but have been forced to string together other funding from a wide array of entities ranging from individual donors to corporations to the people of Cut-ter.

If you could show the map, I would appreciate it.

[Slide shown.]

You have heard a lot today about something called the PATH network and while we are proud of what we are able to do for patients at our own medical home at Covenant House, we really could not do this without our community partners. We are part of a larger system of care that has emerged since the storm to fill the void left when our traditional safety net was essentially washed away. The projected map shows the clinical providers in this group, many of whom are sitting here at this table today. We call this the Partnership for Access to Health Care Path. This pre-storm entity has actually gone from being a simple way to connect health information to actually being a loose network that includes government, faith-based, not-for-profit clinical entities.

Every dot on the map represents a clinic of some sort. Some are small, school based, some are mobile units, some are still tents, but really many are becoming more permanent sites in these neighborhoods.

Inclusion in the group by the way is open to any one who is willing to share in our core values of quality and cost effectiveness and the mission of serving the underserved.

They worked together to fill gaps in services and develop models in the medical home, and altogether we are able to take care of about 900 patients a day, most all of whom are uninsured and representative of the rich diversity that is our new New Orleans.

With continued support and additional resources, I believe that PATH could serve as the core of a future medical home system of care that really could transform health care in Louisiana.

Despite our rosy progress, we do face many critical challenges that have been described already today but I will highlight a few. Our major limitations involve poor access to specialty care and diagnostic services. For example, our patients don't have access to colon cancer screening or diabetic eye care. We don't have access to urgent diagnostic studies for like brain imaging for example, and so we sometimes need to rely on sending patients to the emergency room for such tests which is a highly expensive alternative, or patients often go without, arriving eventually at the hospital with significant or long-term health consequences that is a much more expensive alternative and makes them non-productive members of our community.

As you might imagine finding clinical personnel willing to either stay in or move to New Orleans is quite the challenge. They have rational concerns about long-term job security and find it difficult to maintain a high standard of practice in a broken environment. This shortage of clinicians mean that we are turning patients away every day.

So what can you do? The most cost-effective means to rebuilding our health system I believe is to build a robust primary health care system. This will unclog the overwhelmed hospital system because it will prevent hospital admissions and help save money through slowing the progression of chronic disease.

The three ways that I think you can help are extend the SSBG deadline to provide further resources for funding through that revenue stream as well as provide further resources through the deficit reduction act funding. As was mentioned, at the end of July, our Federal funding from SSBG will end and would like to request at least a 1-year extension on that deadline.

I also believe that perhaps using the discretionary DRA funds could be a way to support and grow more primary care infrastructure to provide a bridge to our future health care system.

Number 2, we need more financial support for clinicians to help with retention and recruitment in the form of loan repayment, malpractice support, SBA loans, as well as uncompensated care payments directed at physicians, and finally, through the expansion of coverage such as programs in Medicaid.

And the third thing is I would like to ask you to assist us as we progress, and please hold us accountable for what we are doing. This hearing has been a catalyst for us locally. We have had better

communication and coordination than we have had in months. It has made us all stop and clearly articulate what we think we need to provide the immediate care for our population.

So we look forward to continuing to work with you. And I certainly want to invite you to come visit our clinics in the city of New Orleans.

Thank you very much.

[The prepared statement of Dr. DeSalvo appears at the conclusion of the hearing.]

Mr. STUPAK. Next we will hear from Donald Erwin, president/CEO, St. Thomas Community Health Center. Dr. Erwin?

STATEMENT OF DONALD T. ERWIN, M.D., PRESIDENT/CEO, ST. THOMAS COMMUNITY HEALTH CENTER

Dr. ERWIN. Good morning, Mr. Chairman. I am Dr. Donald Erwin, representing the St. Thomas Community Health Center in New Orleans.

I would like to thank you for holding these hearings and for the continued interest you have shown in our community. I am pleased to be here to add to the discussion.

St. Thomas Clinic is one of the PATH clinics which was established in 1987 by a partnership with the residents of the country's oldest public housing development and leaders in the medical and faith-based communities. These citizens simply wanted accessible primary care in their community.

For 20 years, St. Thomas provided care to all patients regardless of ability to pay. Pre-Katrina, St. Thomas primarily served the immediate community. We learned at that time that public/private relationships such as the ones St. Thomas Clinic had had for years with the Ochsner Clinic Foundation are very valuable.

Six weeks after Katrina, St. Thomas reopened and we immediately realized we had a different population of patients. For years the clinic had cared for patients in the nearby community. Post Katrina, we now saw patients from all over the city, many of whom had previously had health insurance through their work. They had been insured all their lives but were now uninsured because their jobs were gone. 7,000 school teachers alone were suddenly without insurance when the school system closed since 50 percent of the physicians who were practicing in New Orleans before Katrina have not returned. St. Thomas also had a substantial number of patients who had insurance but no physician and thus turned to us.

This is worth emphasizing. Even patients with insurance had no place to go for health care because the health care system was and remains overwhelmed.

As we cared for an entirely different patient population without funding to support this new demand, St. Thomas sought partners. The clinic developed partnerships with supporters who worked with us and with each other to maximize their support to our clinic.

I am not sure of the patient numbers in the first chaotic months, but over the last 15 months, over 23,000 patient visits have occurred on our clinic's 5,200 square feet of space. Through one partnership, St. Thomas is now the only site in the city where unin-

sured women can receive mammography with appropriate follow-up care as necessary.

As another example, a group of eight different organizations joined together to provide our patients care for cardiac disease at St. Thomas. Since Katrina, St. Thomas has received support from over 30 sources. The clinic now offers primary and preventative care as well as specialty consultations and six different medical and surgical specialties.

Last month we leased a building to provide mental health care to the community. We need funds to support this development. As one physician mentioned, we are not seeing post-traumatic stress syndrome yet because the trauma is not yet over. We find that the relationships we have with the other PATH clinics benefit both of us equally.

St. Thomas raised \$1.4 million in the last 18 months. We had no choice but to try to do so since the needs of our patients were great and they had no place else to go for care. The country has been generous to St. Thomas. In turn, we are good stewards and amplify the gifts we receive.

But St. Thomas cannot live on philanthropy. We cannot survive that way. The St. Thomas Clinic has no guaranteed or predictable funding. As the chairman mentioned, there are broad policy discussions going on now about the future of health care in Louisiana. But whatever model is ultimately accepted is years away from implementation.

In the meantime, St. Thomas and PATH clinics like it will continue to provide major care for the uninsured. We predicted a financial deficit of \$800,000 this year. We were relieved to be eligible for \$755,000 from a Social Service Block Grant. This as a critical source but it was for only 1 year. We estimate another \$800,000 deficit for the coming year, again to be covered with patchwork financing.

St. Thomas is emblematic of several small clinics that have become the type of efficient and effective providers needed to care for large numbers of uninsured patients. But these clinics need help. If we would not be there, there would be long lines at other clinics, more overcrowded emergency room visits, and more expensive hospitalizations. High quality primary care is the least expensive way to provide the best medical care in the community.

I urge Congress to develop a process to provide gap funding for primary care clinics like St. Thomas that have no guaranteed recurrent funding. Whether it is through SSBG or some other mechanism is not for me to postulate, but I do hope that you agree that St. Thomas and other clinics like it are essential to providing care for the uninsured; and I hope you will continue to support our efforts to provide care for the citizens of our community.

I ask that you find a way to provide St. Thomas and other safety-net clinics with predictable, sustainable funding. I appreciate the opportunity to speak to you and thank you again, Mr. Chairman.

[The prepared statement of Dr. Erwin appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Dr. Erwin. Next we will hear from Dr. Evangeline Franklin, director of Clinical Services and Employee Health, City of New Orleans Health Department. Dr. Franklin?

**STATEMENT OF EVANGELINE R. FRANKLIN, M.D., DIRECTOR
OF CLINICAL SERVICES AND EMPLOYEE HEALTH, CITY OF
NEW ORLEANS HEALTH DEPARTMENT**

Dr. FRANKLIN. My name is Dr. Evangeline Franklin. I am director of Clinical Services and Employee Health for the New Orleans Health Department, also a member of the Partners for Access to Healthcare.

To you, Mr. Chairman, and to Ranking Member Whitfield and distinguished members and guests of the subcommittee, I would like to thank you for the opportunity to speak to you today about the two outdoor health clinics in New Orleans the Health Department recently held in the city of New Orleans.

Mayor C. Ray Nagin and members of his administration have sought creative means of addressing our citizens' critical health needs as we work to recover from the tragedy of Hurricane Katrina and the subsequent flooding.

Today I would like to describe to you a city, indeed a region, which continues in health crisis despite the efforts of all of our organizations. This crisis results from a combination of factors. The people of New Orleans face many challenges such as the difficulty of returning to rebuild homes and businesses, the tendency to ignore their chronic illnesses that these stressful distractions have caused or exacerbated, and the complexity of the processes to claim insurance proceeds or funds from the Louisiana Road Home Program, the State initiative to compensate homeowners for their losses in Hurricanes Katrina and Rita.

All of these factors are complicated by a health care system that is itself damaged and under stress, further limiting the access to health care that even before Katrina was not ideal.

In the aftermath of the hurricane, the population of the uninsured in New Orleans has expanded from traditionally uninsured groups to include many who have experienced sudden loss of benefits, including individuals who were laid off from jobs because of the destruction of their place of employment or due to loss of market or tax base. Many of these people returned to New Orleans following the floods because of personal or business financial commitments or because they simply just wanted to come home.

The composition of our uninsured also includes persons who cannot speak English and those who cannot secure health insurance because of their migrant worker status or because they lack the proper immigration documentation. Many of our uninsured are part of the working poor who toil daily in their jobs but who are not offered or who cannot afford insurance.

Hurricane Katrina and the subsequent flooding were responsible for the loss of many aspects of health care including hospitals, doctors, medical records, and pharmacies. It has also meant that many people lost their medications and let us not forget their dentures and their eyeglasses.

This when coupled with the physical and psychological hazards of devastation have put patients previously stabilized at risk. Imagine trying to fix your house when you cannot see.

I was assigned to coordinate two large-scale health care events designed to provide medical, dental, and optical services and to assist in organizing follow-up. Helping patients regain some control

of health problems would enable our community to better manage health resources such as emergency room use and admission to hospitals.

Both of these 7-day events were highly successful. Thousands of patients were able to proceed from each outdoor event with a 30-day supply of needed prescriptions as well as eyeglasses, dentures, immunizations, pap tests, and information about where to obtain follow-up medical care at many of our participating clinics. But this occurred only after they endured long lines, sometimes waiting all night in cold and rainy weather to be treated on a first-come, first-served basis by volunteers throughout the country as well as local professionals. Typically capacity for each day was reached within an hour of opening the registration. As a result, many of those who needed care were unable to receive it and had to be turned away to be seen on another day or at other locations.

The first of these events was held in February 2006 at the Audubon Zoo, a location considered to be an oasis in the middle of destruction. Audubon Zoo made a significant contribution by allowing us access to their grounds to set up the clinic locations, by housing the volunteers who came from all over the United States, and by having their employees contribute their time for this seven-day event.

The event was an immediate success in large part because of its location and accessibility by car and by bus, but many people also walked to the event. The zoo is located in an area of the city which was among the first to repopulate because of the lower level of damage that it sustained from flooding. FEMA trailers were still being installed across the city.

Because of the magnitude of the catastrophe, very few safety-net clinics and pharmacies were open at the time soon after the flooding. Many weary patients reported that they were unable to locate their doctors, did not know where to go to have their prescriptions filled or refilled. Others offered poignant stories about their inability to obtain needed care, medications, and immunizations.

Of the 5,212 patients who received care at the Audubon event, 27 were transferred to local hospitals for emergency care. One of those was a revived cardiac arrest. This woman was having her cholesterol tested, unable to get it tested at any other local institution; and during her visit at the Reach 2010 at the Heart of New Orleans facility of the health fair, she had a heart attack. She was unable to obtain primary care but could be cared for after having a life-threatening emergency. Fortunately, she is currently doing well.

Others were not so fortunate. One gentleman was given the diagnosis of metastatic cancer. He had been told at one of the local private hospitals that he had to pay for his diagnostic tests before he could receive treatment. He did not have the required money and was refused that treatment. Because Charity Hospital had not yet reopened, there is no public facility in the city that could provide the cancer care. Further complicating his situation, this man could not speak English and had no transportation. Despite these difficulties, we arranged for this gentleman to receive care at another facility out of town.

Many of the volunteers during the week remarked that they had never seen so many people who were so very sick. All in all, there were 1,300 volunteers who treated the 5,200 patients during this event. Prescriptions were filled at no charge and social services, including mental health, were made available for interested patients. Volunteers traveled at their own expense. The value of the services provided was \$1.9 million.

The second event was held a year later in conjunction with Operation Blessing who is represented here today. This organization represents a clinic with medical, dental, and pharmaceutical services in eastern New Orleans. The week-long Health Recovery II was an outdoor clinic as well. The New Orleans East location of Operation Blessing was accessible by car and bus and had become an anchor by providing free care before Health Recovery Week II.

This again was an idea location for the second event but this time because neighboring communities have shown signs of return and rebuilding. FEMA trailers placed in front of houses in New Orleans East and the sale and purchase of property for renovation herald the return of significant resources in terms of professional and business community members. In addition, citizens from eastern New Orleans were part of the regular patient population of Operation Blessing. Because the medical director is fluent in Spanish and Vietnamese, non-English speaking residents are drawn to this facility. In addition, this location does not interfere with the function of clinics and services in other parts of the city where population has stabilized.

For this event, Operation Blessing invested over \$500,000 in the project for the cost of supplies, lab work, pharmacy services, infrastructure improvement, marketing, and food and lodging for the volunteers at their Slidell, Louisiana, command center.

Even though more medical facilities and safety-net clinics had been opened in the intervening year, the story was exactly the same as before. Fewer patients were treated but only because there were fewer volunteers who could see them. Again, patients waited in the cold and the rain and were willing to be seen in tents for their medical, dental, and optical care. And again, citizens frequently stated that they could not find their doctors and did not know where to get their medications.

The vast majority of patients seen during this health intervention week had never been seen at Operation Blessing, and many had been referred by other clinics to receive services that were not available there, in particular for their denture care and for their eye care. Of the over 3,800 patients who were seen in the seven-day event, 21 were transferred to local hospitals. As in the first Health Recovery Week, hundreds were turned away after the capacity of the event filled within the hour of its opening.

Mr. STUPAK. Doctor, can you sum up, please?

Dr. FRANKLIN. Yes, I would like to say that given the contribution of volunteer care in the city of New Orleans, I think attention should be made for that to continue as a stabilizing proposition until we can recover the system. Further recommendations will be provided by Dr. Kevin Stephens in his testimony.

Thank you

[The prepared statement of Dr. Franklin appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you. Dr. Gary Wiltz is chairman, region 3. Explain where region 3 is to us first.

Dr. WILTZ. I will do it as I give my testimony.

Mr. STUPAK. Thank you. You may start.

STATEMENT OF GARY WILTZ, M.D., CHAIRMAN, REGION 3 CONSORTIUM

Dr. WILTZ. Well, good morning, Mr. Chairman, and the members of the committee and it is a special honor to appear before my Congressman, Mr. Melancon.

Thank you for the opportunity to speak with you today about the very serious and continuing health consequences of Hurricane Katrina's aftermath. But I come before you today wearing many hats. First and foremost I am a practicing, board-certified internist and the CEO and medical director of the Teche Action Clinic, a federally qualified community health center established in 1974 located at Franklin which is a small, rural community 100 miles southwest of New Orleans. I am also chairman of the Governor's appointed Region 3 Health Care Consortium which includes seven rural parishes located immediately outside the New Orleans area. I also serve on the Board of Directors of Louisiana Primary Care Association or the LPC which represents State's 21 FQHC's. And finally, I am the Board Secretary of the National Association of Community Health Centers.

I would like to begin by telling you a little bit about my personal history. I was born at Charity Hospital in 1953 on the colored ward section of the then-segregated hospital. I earned a scholarship to Tulane University and later attended Tulane Medical School where I was fortunate enough to receive a National Health Service Corps Scholarship. Ironically, I did most of my residency training at the same institution where I born, Big Charity, in New Orleans. Upon completion of my residency, I was assigned to Teche Action Clinic in Franklin to serve my 3-year obligation service pay-back. Twenty-five years later, I am still practicing medicine at that same site.

In speaking of the health care realities in my home State today, I must begin by noting the sad reality that Louisiana's health care system was broken pre-Katrina. Louisiana had the dubious distinction of having consistently ranked 49th or 50th among the States in the United Health Care Foundation's annual health status report over the past 10 years. Our health care system has been characterized as fragmented, expensive, and ineffective, producing far too many health outcomes.

The original concept of the Charity Hospital was to demonstrate the compassion of the people of our State. It was perfectly named to fulfill its founding purpose, to provide charity. The flagship of this system located in New Orleans fast became known affectionately by the locals as The Big Free. Unfortunately as we all know, nothing in life is truly free. Pre-Katrina, the residents of the seven rural parishes that represent the Consortium depended on Charity Hospital. Katrina essentially destroyed the health infrastructure of the entire southeastern part of Louisiana. It also decimated the

health care workforce by displacing more than 6,000 health care professionals, most of whom have not returned.

In the immediate aftermath of Katrina, our surrounding parishes saw evacuees overflowing into our communities. My family personally housed 19 family members for many months after the disaster hit, and I am proud to say that Louisiana's health centers responded to this tragedy as best we could but there is still much more to be done.

Now fast forward 18 months, and where are we today? To borrow a line from the play, *The Music Man*, "Oh, we have got troubles right here in River City". To underscore how serious our problems are, I give you several true-case studies. Number 1, a 38-year-old uninsured male with a diagnosis of bipolar disorder is brought to the hospital emergency room by a Sheriff's Deputy. Family members say that he has not seen a psychiatrist in 18 months because of Katrina. He remains in the hospital emergency room for 72 hours being sedated for his own and everyone else's protection, only to be finally released to his family when no other recourse could be found.

Second, our region's only pediatric psychiatrist has left the area leaving hundreds of children who were under his care in the hands of their primary care pediatrician. Our psychiatric nurse practitioner in our system alone has a 2-month waiting list and is seeing children now, because of the delays are now unmedicated and have decompensated.

Finally, a 57-year-old female with chronic neck pain that has caused numbness in both her arms and hands and decreased motor strength has Medicaid so we were able to get an MRI and discovered she needs a neurosurgeon. But there are no private neurosurgeons who accept Medicaid. With Charity now closed, the only neurosurgeons accepting Medicaid are located at the LSU charity hospital in Shreveport, a 6-hour drive from her home, but if only she had transportation to get there.

So now that we see what the current landscape looks like, might I suggest some solutions? Let me so that while the scope of the problems we face in our communities are so great that they will require the kind of money that only the Federal or State government can provide. The best solutions, however, are not likely to be crafted out of Washington or Baton Rouge. Let me add one more important point, that simply providing health care insurance to the many uninsured, while that is a crucial step to make health care affordable, would do little or nothing to make health care available or accessible. We need a model that works, that is proven, that is cost effective, culturally competent, and that can serve as a medical home, a health care home in fact. And the beauty of it is such a model already exists in our Nation's community health centers.

Expansion of health centers would quickly address both the needs of the underserved across our Nation and be a critical step in transforming our health care system. The Federal Government could immediately fund all the applications from Louisiana that are already sitting at HRSA and greatly expand access to care immediately. Coupled with an expansion of the health center's program is the need to expand the National Health Service Corps, the very program that brought me to the community in need a quarter-

century ago. We need a statewide expansion of the Nation Health Service Corps that recognizes the needs of rural Louisiana.

In closing, I leave you with the immortal words from Dr. Martin Luther King, Jr., that are as true today as they were 40 years ago when he uttered them, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Thank you once again for this opportunity, and I will be happy to answer any questions you might have.

[The prepared statement of Dr. Wiltz appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you and thank you to all of our witnesses. As I said earlier in my opening, your courage and heroism is an inspiration to all of us, but that is not going to solve the health care problems in New Orleans and that is why we are here and we are going to stay with you and we are going to get this thing moved, prodded, whatever we have to do to move this thing along.

I said in my opening that our hearing will focus on what health care providers believe is the most urgent health care issues that need to be addressed in the short term, and I certainly get the impression from this panel that the dollars have to follow the patient. Some of you said that directly in your testimony, others have alluded to it. We certainly understand the Social Service Block Grant money, the CDBG money, and other issues we must come to cope with.

If we take the money out of it for a moment, just for a moment, what else do we need in your opinion? Give me one thing you think we should do, that Congress can push to do, that should be done to help you out? Ms. Rowland, we will start with you and then proceed right down the line.

Ms. ROWLAND. I certainly think acting on some of the recommendations that have already been put forth to the Department such as expanding availability of community health centers so that the funds can be released for that, extending the Block Grant was one issue, but I think really putting the resources of the Public Health Service together with needs on the ground to use every available resource that the Federal Government has to help build community health centers, to help build more mental health capacity, and as the last speaker just mentioned, to bring the National Health Service Corps in to help to establish some of the doctor needs during the time when you are recruiting back positions.

Mr. STUPAK. Mr. Koehl?

Mr. KOEHL. The only thing that we would ask would be this group push to allow our volunteer nurses to come and work. Without them we will only see 25, 30 patients a day. These nurses triage, they take vitals, they dress wounds, they assist the physicians in every way possible.

Mr. STUPAK. Is that more than just nurses?

Mr. KOEHL. Nurses and nurse practitioners will no longer be allowed to volunteer in the State of Louisiana by the end of this month without the Louisiana State Board of—

Mr. STUPAK. By the end of March?

Mr. KOEHL. Yes, if they will not allow them to come volunteer. And our nurse practitioners are providers just like doctors, so that will limit the number of patients that are being seen.

Mr. STUPAK. Any other medical profession run into the same thing, where they cannot volunteer?

Mr. KOEHL. No.

Mr. STUPAK. It is just the nurse?

Mr. KOEHL. Different board, different group of people making the decision.

Mr. STUPAK. OK. Dr. Fontenot?

Dr. FONTENOT. Unfortunately I think it ultimately comes down to money, but certainly helping in the recruitment efforts by using U.S. Public Health Service Corps. The regional designation for underserved community probably applies to more than the four-parish area that is currently designated as I understand it and redeveloping infrastructure, namely electronic means of sharing data among the partners who are now responsible for providing care.

Mr. STUPAK. OK. Dr. Bertucci?

Dr. BERTUCCI. Well, and again, it does come to money. It does come to money. We need to get our primary care physicians back and our specialists back so that we can do medical homes. Without those particular individuals, it is impossible. It does come down to the fact that we do need dollars. In order to have a medical home, you have to have primary care physicians, you have to have specialists, and you have to have some buildings for these people to work in.

Mr. STUPAK. But didn't you say you have to start with the primary care in order to get the specialists to come in?

Dr. BERTUCCI. I agree with that. We need buildings, though, to put those people in. Right there in our particular parish we are kind of unique in the fact that we do not have buildings to stick people in, and even if the specialists wanted to come right now, we wouldn't have a place to put them.

Mr. STUPAK. Right.

Dr. BERTUCCI. So we need some of the SBA loans so that they can build.

Mr. STUPAK. Sure.

Dr. BERTUCCI. We need some low-interest loans for people who don't qualify for SBA so they can build. So I think those are the biggest things, and I think the bridge money so we can sustain our clinics, especially the rural reimbursement, would help us tremendously in both maintaining our clinic and building a hospital.

Mr. STUPAK. Dr. DeSalvo?

Dr. DESALVO. You could come rip up the frayed carpet in our stairwells so it wouldn't be so hard for people to get up and down the stairs and help us slap some paint on the walls, but aside from that—which we will pay for the paint, by the way—I am a National Health Service Corps person as well. I was assigned to Charity Hospital and was retained, apparently, for all these years. And so I think it is an excellent program if some of the bureaucracy is weeded out so that if we know there are people who are using that for loan repayment and they will be assigned to New Orleans.

Mr. STUPAK. Let me ask you this. Let me just follow this up a little bit. And I know I did not want to talk about dollars, while I got you here I only got a few minutes left, what about DSH dollars going to clinics and doctors?

Dr. DESALVO. I am sorry?

Mr. STUPAK. What about DSH going to clinics and doctors?

Dr. DESALVO. I am not a DSH expert, but from what I understand—

Mr. STUPAK. But you are a practical expert so I want practical answers.

Dr. DESALVO [continuing.] experience is that the way we DSH in Louisiana it doesn't—we can't apply for that through matching dollars at our clinic—

Mr. STUPAK. We have to get a State or Federal waiver, right?

Dr. DESALVO. I would have to refer that to Diane.

Mr. STUPAK. Ms. Rowland, we also get a State waiver, I believe, if I am right.

Ms. ROWLAND. The DSH funds actually flow through hospital and inpatient hospital care. So you would need a waiver under Federal law to use them for alternative sources.

Mr. STUPAK. OK. So you need State waiver and Federal waiver?

Ms. ROWLAND. You need the State to request a Federal waiver. It is the Federal Government that would—

Mr. STUPAK. But the State would still have to change its law, though, to allow it to go other than hospitals to clinics. So you need a change in State law, then they have to apply for the Federal 1115 waiver, correct?

Ms. ROWLAND. Right, and there was a previous waiver that was pending at the time Katrina hit that you reactivated and as a small point, I mean, I would say yes, we need money. We just need money.

Mr. STUPAK. Right.

Ms. ROWLAND. But the SSBG's for example is essentially a no-cost extension is what we want.

Mr. STUPAK. Dr. Erwin?

Dr. ERWIN. I would like to see whatever way we could do it that we develop an incentive to focus on partnerships of these primary care clinics with specialty providers and hospitals. Where we have been most successful at St. Thomas has been the ability through collaborations and sometimes paying for the specialists, to be able to provide timely outpatient specialty services. Everybody agrees that the highest quality, most cost-efficient care is when the physician who knows the most about that specific illness manages the patient. And when we get used to thinking of specialty care as the tertiary hospital specialty care, and I think there are so many instances where the cardiologist helps patients out of the hospital by managing their heart failure and the nephrologist helps prevent patients going onto dialysis by appropriately intervening. So I would really like to encourage you to help provide whatever incentive is possible to link the primary care clinics with specialty services and hospitalization.

Mr. STUPAK. OK. Dr. Franklin?

Dr. FRANKLIN. From our experience at Operation Blessing and from our experience in the health clinics in New Orleans, I would like to focus on cultural competence in medical translations being part of the practical problems that we actually have to approach. We have numerous individuals in the city who do not speak English. We have had a population of Hispanic and Vietnamese before the storm, but the population, especially of non-English speak-

ing Hispanics, has increased. Since my colleagues have done such a good job of talking about the medical issues, DSH dollars, that sort of thing, I would like to focus on eyeglasses, optical care. As I said, imagine trying to find a job or fix your house when you can't see.

Mr. STUPAK. Dr. Wiltz?

Dr. WILTZ. Yes. Mr. Chairman, I think you actually hit on it early on, the chicken or the egg; and I think the problem is we need both concomitantly workforce development as well as infrastructure. Before I left, I saw an e-mail that I don't know where it generated from but there was something being bantered about that there was a \$15 million grant from DHH that was described as a New Orleans Health Service Corps that was being offered, and maybe one of the other panelists will allude on that. But I think something in that regard that is expanded for all of Louisiana, particularly in the rural communities outside of New Orleans that were sort of depended upon Charity Hospital for specialty and subspecialty care and of course the development of FQHC's.

Mr. STUPAK. I think that \$15 million was something Mr. Melancon has been working on for a while. Maybe he can expand on that a little bit more.

Let me ask this question here. Dr. Fontenot, if I live in New Orleans, I have lost my house, my job, I have no health insurance, and let us say I have some type of cancer and I used to go to a clinic at Big Charity for my chemotherapy, what do I do now?

Dr. FONTENOT. You probably still come to Charity, either through the emergency room or through its primary care clinic and get referred to a sister public institution about 60 miles away where there are oncology services available.

Mr. STUPAK. As Dr. Wiltz said, transportation isn't the best in New Orleans right now. So I am unemployed, don't have any money, I don't have a house. Well, why can't I go to one of the private hospitals there?

Dr. FONTENOT. Unless there is an emergency pending and you need emergency care through their emergency department, I believe they would have difficulty in referring you to a private oncologist in town because at that point, you would need diagnostic services and you would need chemotherapy which is quite expensive and likely would be——

Mr. STUPAK. Are there any clinics there doing chemotherapy or anything like that?

Dr. FONTENOT. Not for uninsured patients currently, no, sir.

Mr. STUPAK. If I went to emergency room at a private hospital, would they accept me because it is chemotherapy? Does that qualify as an emergency?

Dr. FONTENOT. No, sir.

Mr. STUPAK. Because it is just a continuation of treatment of my illness, right?

Dr. FONTENOT. Maintenance of, yes, treatment of your non-emergent illness.

Mr. STUPAK. My time has expired and I yield to the ranking member for 10 minutes. Mr. Whitfield?

Mr. WHITFIELD. Thank you, Mr. Stupak. All of us were quite moved I think by the statistics that you all presented in your testi-

mony. 48 percent more people dying each month and 90 percent of employees losing jobs at Charity University Hospital and so forth. And it is so overwhelming what you face it is really difficult to decide where to begin.

But I would like to ask the panel, is there one entity within the region that all of you work with to make presentations to the Federal Government and the State government on the needs of the health care providers? Is there one entity that is speaking for all of you or do you do it separately or how is that handled?

Dr. DESALVO. The way we have informally developed that kind of communication is through the PATH network, the Partnership for Access to Healthcare, so that even though it is a federation and we don't officially lobby, we do have an administrative entity, the Louisiana Public Health Institute, that can bring us, convene us, coordinate us, send out information and does things like make these maps so that we can visually see where we need services and then look at grids of gaps.

Mr. WHITFIELD. Right.

Dr. DESALVO. They also then help communicate with the State government for us about what future resources might be.

Mr. WHITFIELD. OK. So PATH is sort of the lead agency for all the health care providers in the area?

Dr. DESALVO. Not an agency, it is a collaboration.

Mr. WHITFIELD. OK. Collaboration.

Dr. FONTENOT. If I might, we actually communicate and have very good communication with Dr. Cerise with the Department of Health and Hospitals who is the Secretary of DHH. And so he is kept in the loop as far as especially the regional needs and how we work together.

Mr. WHITFIELD. Dr. Bertucci.

Dr. BERTUCCI. We also participate in the Recovery Council which has representatives from Plaquemines, Cameron, St. Bernard, Orleans, and St. Tammany Parishes and also East Baton Rouge. So we also give information to them and serve mainly as an information center so that we can give that out to people of the needs, medically, psychiatrically, et cetera, of the different parishes. We serve more as an informational type situation.

Dr. WILTZ. We also have the Regional 3 Consortium. Actually, the Governor had a Health Care Commission that was convened pre-Katrina and we were meeting on an ongoing basis to address a lot of health care needs. Post Katrina, we continue to meet those seven rural parishes that I represent, and there are some other regions that are also meeting and we do present to Dr. Cerise on an ongoing basis.

Mr. WHITFIELD. All right. Now, prior to Katrina, how many hospitals were there in the New Orleans region? Does anyone know?

Dr. FONTENOT. I believe that there were about 12.

Mr. WHITFIELD. Twelve?

Dr. FONTENOT. Don't hold me to that number specifically, but there were about 4,400 hospital beds.

Mr. WHITFIELD. OK. And how many hospitals are operating today?

Dr. FONTENOT. In Orleans Parish, there are four including a children's hospital that does not treat adults, three others that are operating in Orleans Parish.

Mr. WHITFIELD. But in Bernard Parish there are zero, is that correct?

Dr. FONTENOT. Bernard has none.

Dr. BERTUCCI. St. Bernard had 240 hospital beds but the population was 67,000. Right now we have zero beds and a population of 25,000 that once the elderly and the Road Home Funds come we assume more people will come; and in 2 years we anticipate about 35,000 back and are working diligently to try to get a 40-bed hospital.

Mr. WHITFIELD. And Dr. Wiltz, out in Franklin, you have a hospital in operation out there now?

Dr. WILTZ. Yes. As a matter of fact, we have a new hospital that is being constructed. That will be open in July, but that was in the works pre-Katrina.

Mr. WHITFIELD. Now, in the testimony it is quite obvious one of the major problems that you have is primary care physicians, and as someone that is a little bit biased toward these community health centers, I mean, I really see community health centers as being able to provide a major role in health care delivery around the country myself. I may be wrong, but that is the way I feel.

Mr. WHITFIELD. Dr. Bertucci?

Dr. BERTUCCI. Well, I am a private physician and I have to say this. I thank and I admire the public health system, don't get me wrong. But don't discredit private fee-for-service doctors.

We get paid and compensated much less and provide tremendous services very, very efficiently. We are very cost effective, very productive because we have to be. We don't get subsidized, we don't get help. And we are trying to attract back the private primary care and the private specialists because I think these people need to be there, too.

We need the public health network as an umbrella, it is a safety net, and also for service for the indigent; but we as primary care doctors probably saw—I saw people for free all the time. So don't discredit the fee-for-service.

Mr. WHITFIELD. Well, I appreciate your comments on that. I think many of us outside of these disaster situations have looked at the community health centers being expanded to help address the uninsured for lack of a better—or people who simply don't have access—people who go into the emergency rooms—keep them out of the emergency rooms. And I agree with you, though, that we don't need to ignore fee-for-service primary care physician.

Dr. BERTUCCI. At our clinic and in my clinic before the hurricane, no patient was ever turned away for money. Now, if they were rude, that is a whole different story; but for money, it is a different thing.

Mr. WHITFIELD. Right.

Dr. FRANKLIN. Mr. Whitfield, I would like to say that approximately three-quarters of the private physicians that were in Orleans Parish are no longer there. The Health Department continues to get calls from private physicians who want to come back to the city who are looking for employment, looking for an opportunity to

re-establish their practices, knowing that we have brick-and-mortar opportunities for them to work.

Mr. WHITFIELD. Right. Three-quarters, these are fee-for-service that are no longer there.

Dr. FRANKLIN. Yes, that is correct. That is the estimate, yes, sir.

Mr. WHITFIELD. Now, one of the things I remember from our hearing in January, my memory may not be accurate so you all can correct me but what raised this issue in my mind, Mr. Bertucci, you were talking about the fee-for-service providers were penalized by FEMA because you were a fee-for-service. You were not eligible for funding, is that correct?

Dr. BERTUCCI. Actually, it is if the hospital was fee-for-service.

Mr. WHITFIELD. OK.

Dr. BERTUCCI. And therefore every time we applied for any type of financial assistance, they said that you didn't qualify because everything is based on pre-Katrina which is fee-for-service. And I will just leave it at that.

Each time we ran into those dead ends, we tried to—never in the history of the United States they said has a fee-for-service hospital not come back. And I said, well, they are not coming back right now. What do we do?

There is no answer to that. So it is not private physicians, this is a hospital.

Mr. WHITFIELD. Yes. I am going to ask you a question and I mean I know the focus of this hearing is what can we do to help, and all of you answered the chairman's question specifically and you listed about 12 or 13 things that could be done immediately. But I remember in that January hearing some of the what I will say fee-for-service hospitals, private hospitals, were very close to going back into operation because they said all of them had insurance and from the insurance proceeds they could build back and get back into business. The State-operated hospitals were self-insured and with the size of the catastrophe that hit, there were not enough State funds to get them back in operation. So at Chalmette, if that was a private hospital, what about the insurance proceeds?

Dr. BERTUCCI. Chalmette was in a dilemma where it had just expanded our hospital by 17 ICU beds and 40 private beds, had bought Methodist Hospital and Lakeland Hospital. So they also lost those other facilities at the same time. I don't know their insurance situation, although I saw an article in the paper so I don't want to quote things that are not true. But they did list the monies that they did receive, but their intentions appear to be that they are not coming back to this area. None that I know of at this point. So we recruited a non-profit group, the Franciscans, to help us to secure funds to make our dreams come true.

Mr. WHITFIELD. Yes, well, Mr. Chairman, as we said, this is an overwhelming problem that we face, and I recognize the importance of fee-for-service and do everything we can to encourage private, paid physicians to come back. But I do hope that our committee, full committee as well as subcommittees, can work to try to provide expedited facilities and funding for community health centers to provide that instant primary care help that is needed in that area.

I will yield back the balance of my time.

Mr. STUPAK. There might be some good questions there for the third panel and ranking member's thoughts. Mr. Melancon, from Louisiana for 10 minutes, please.

Mr. MELANCON. I want to thank you all for taking the time to come here. I think the more I listen, the more questions I start having in my mind. I am not an authority on health care, but I am starting to see pieces starting to fall in and coming to understand what is going on.

I guess what one of the things that we want to see happen, and the chairman and I and others have talked about it, we don't want this to be you come here and testify and you go home and we will kind of try a couple things and we will see you later. What our discussions have been are to bring the facts out as much as we can, try and make incremental steps here at the beginning with recommendations from you what the Feds can do, what maybe we can do to prod the Department of Health and Hospitals or whomever to move things. But in roughly maybe 45 days or whatever the chairman decides to come back and revisit that, whether it is here in Washington or back in New Orleans and see what we have been able to accomplish, see what you have been able to accomplish, see what new problems are out there. And I guess the question to anyone in particular, do you think this would help us to start that track towards getting health care in the southeast region of this State back going in the right direction, and if so, do you have any specific things, suggestions that we ought to be making sure that gets done? Ms. DeSalvo?

Dr. DESALVO. Mr. Melancon, I mentioned this in my testimony that I do think it would be helpful. I think the oversight has caused some coordination in the community, being a sort of neutral party, helps to step in. We have been meeting ourselves to death for 18 months, so let us just remember that when we are doing it. And I would also say that the funding relief issue is really urgent, and I am not sure we can wait 45 days. We spend so much time begging for dollars from foundations just to keep our doors open, so while we are planning things, let us make sure we provide some immediate funding relief in some way so that we can focus on the other issues.

Mr. MELANCON. Doctor?

Dr. ERWIN. Yes, sir. I would certainly second that and I would certainly hope that you do come to New Orleans and the other parishes again mainly because speaking just for myself, I am not involved a lot in policy. I am sort of in the forest and sort of laboring every day and it is easy to kind of lose perspective. You are just thinking about yourself and how to get through the day and the patients you are seeing and how can I get this particular person any assistance, and it is so beneficial when people come to town who have knowledge, who have an overview, and who have the ability to change direction and to influence decision makers in Washington and in the State and everywhere else. I would certainly hope that you do come back and keep the focus that you are showing today and have shown.

Mr. MELANCON. Dr. Bertucci?

Dr. BERTUCCI. Yes, I think it is important that we become your information source so that we can tell you pluses and the minuses

of the things that we have been able to accomplish. I think that is extremely important. I think we always say be careful what you ask for because you might get it. And the problem is that right now, we are asking for specific things; but in 6 months, I can tell you the way things change, the problems will be different. So I do think it is important that we have the opportunity to verbalize the situation to you so you can have good information, updated information to make decisions on.

Mr. MELANCON. Dr. Wiltz?

Dr. WILTZ. I think it is critical you keep the spotlight on the issue. I think it is critical that outcomes be measured and progress be measured. I don't think it is enough to throw money at any situation. I think you have to have accountability, and it is going to be interesting. This coming week we are expecting to hear from HRSA if all those applications are pending for new access points as well as expanded medical capacities that have been backlogged because you all just passed a Continued Resolution that opened that funding up. If that comes to pass in the next 6 months, those applications we have to be a mandator to get those facilities up and running in the next 6 months. So it will be interesting to see if those monies come. You know, we can give you a progress report on how that went.

Mr. MELANCON. Dr. DeSalvo, let me suggest being from south Louisiana, hearing politicians come down there and talk and take pictures and come back here and forget what they saw and didn't follow-up in many instances, I have expressed to the leadership in this House that we are tired of hearings. We want things to start happening.

So what I think you see here in this committee, because of the chairman of the full committee and the chairman of the sub-committee, Mr. Stupak, is an effort to do exactly what you are saying, is make the meetings that you have more meaningful and that something comes out of them. And the chairman has assured me that he stands by that. We have got a great staff here that understands the issues and I think will help us.

I want to encourage not only you but any panel members that come to please stay in communication with us or the staff because if you are anything like me, you are going to walk out the door and say darn it, I forgot to talk about such and such.

So those ideas, those thoughts, don't let them fly past. Make sure that we get them because we want to do whatever we can possible. We know that money is a necessary evil, and that is tough but we have got to address that as time goes. But those things that will move us incrementally toward resurrecting health care like it should be in southeast Louisiana and for that matter a ripple effect that is starting to go out into the country areas, we need to catch it now before it gets to be too far gone.

Mr. Chairman, I yield back my time.

Mr. STUPAK. If I may follow-up here on one point. You mentioned these HRSA applications pending before HRSA. How many are there and how long have they been pending?

Dr. WILTZ. We submitted them last year. There was a statewide strategic plan that involved most of the community health centers with anticipating spread and expansion.

Mr. STUPAK. When last year?

Dr. WILTZ. I can get that information to you. I don't have the exact number.

Mr. STUPAK. OK. So it has been pending for a while?

Dr. WILTZ. Yes.

Mr. STUPAK. Have they given you any indication when you can expect a decision?

Dr. WILTZ. We were thinking we would hear something this week. There was no funding available until you all passed that continuing resolution. So we are expecting to hear something hopefully this week or next week.

Mr. STUPAK. OK. Why would they not move your application, approving it pending funding? Why would you use funding as an excuse not to do your work until—

Dr. WILTZ. Some of them were approved without funding because you all didn't have a budget until the CR was passed is my understanding.

Mr. STUPAK. Right, but I would still think that your work would go on, and when the funding came in you could move it. I mean, you are sort of in a dire situation down there in New Orleans. I mean, when we were doing the CR, there was never a question there. The question was just how much money was going to be there.

Dr. WILTZ. Yes, there is also some State legislation pending now that if that goes through, we may have the opportunity to do an even greater expansion project.

Mr. STUPAK. So if HRSA approves your applications, then the State may help you expand these qualified clinics?

Dr. WILTZ. Yes.

Ms. ROWLAND. Mr. Chairman?

Mr. STUPAK. Yes.

Ms. ROWLAND. There is also monies in the Deficit Reduction Act that allowed for development of community centers and access to care that have not been expended yet. So there is additional discretionary funds—

Mr. STUPAK. Well, that was the 2005 Deficit Reduction Act I think was signed into law in January 2006 if I remember correctly.

Ms. ROWLAND. And the Secretary set aside those funds and has not yet allocated most of them, so that would be an issue you could raise in your third panel.

Mr. STUPAK. Allocated because there is no request or allocated because they just haven't gotten around to it?

Ms. ROWLAND. As I understand it, it was set aside. There have been obviously requests for various support for community health centers but have not yet designated how they are going to allocate those funds out from the Department.

Mr. STUPAK. But couldn't the current health centers that we see before us here today access that money then, the Deficit Reduction Act of 2005 which was approved in January 2006?

Ms. ROWLAND. One would assume they could under the terms of the Deficit Reduction Act.

Mr. STUPAK. I mean, that is 12, 14 months from here and we got money sitting here, it appears to be.

Ms. ROWLAND. Well, I certainly think one of the things this committee can help do is to look at where there have been snags in resources that were intended to be utilized quickly that have not been yet utilized, changes that could be made to flow the funds. While it is not about money, it actually is about the money to develop the resources.

Dr. WILTZ. I am just told that there are 287 new access point applications pending nationwide.

Mr. STUPAK. Well, they don't have to wait until the 287th one approved. If they did the first 10, you could move those out, roll them out, get them moving, right?

Dr. WILTZ. I agree, and as our middle name indicates in our clinic, it is called Teche Action Clinic, and we are ready to roll. If we had the money, we could expand within 6 months.

Ms. ROWLAND. One of the things we learned from the Katrina experience is that we don't have very effective emergency crisis management policies in any of our programs, whether it is Medicaid to just quickly be able to extend coverage to people who lose their homes and their insurance or to move the community health center applications through the bureaucratic hurdles. And so I think one thing to really look at is how can we simplify or set up streamlined procedures that in a case like this can relieve the DSH funds and move them quickly from being hospital-based to community-based or to cover people or to set up ways to get these community health center funds—

Mr. STUPAK. Sure but an emergency declaration is supposed to move that red tape quickly so you can respond quickly to the needs of the people who are devastated, and there has been no greater devastation of any natural disaster in this country than this one. So I would think that once you have a disaster declaration, that the critical needs such as health care certainly would be moved and go through this red tape a little quicker.

Ms. ROWLAND. Right, and just as Mr. Green noted, there is no way that if it happened to Houston this year the procedures would be any better or any quicker.

Mr. STUPAK. Yes. Go ahead and then I got to get back because they want us to be out of here by 3 o'clock, and at the rate I am going we will never get to 3 o'clock. We will still be on this panel and we have got two more to go. Go ahead, Dr. Bertucci.

Dr. BERTUCCI. Just one example of finding problems is that when the Social Service Block Grant came out, there was \$110 million. \$30 million of that went to medicine, and our numbers got cut from \$10 to \$7.5 to \$5 to \$3.2 million and this is medicine. Now, I mean we are talking—we need access to funds for running our facilities but also we need some to build facilities. And we are not a public health clinic, so we need help, too, in order to build ourselves so that we can handle the volume that we need to handle in our parish.

Mr. STUPAK. Next we will go to Mr. Burgess of Texas for questions. Ten minutes, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Dr. Bertucci, let me speak with you for just a minute and then we will go to some of these other things that have come up, particularly the snags in the

facilitation. Now, your hospital is Port Chalmette hospital, is that right?

Dr. BERTUCCI. The hospital is Chalmette Medical Center.

Mr. BURGESS. Chalmette Medical Center? And I visited that in October 2005. Of all of the things that I saw when I was down there that October, that hospital was probably the one about which I will have nightmares the rest of my life because it looked exactly like my community hospital in Texas, and I could well imagine what would happen to my community in Texas if suddenly three feet of mud, snakes, rodents, all the things that you talked about, the oil spill. I mean, you didn't need to just see the devastation, you could smell it and taste it in the air still 5 or 6 weeks later. And my understanding is that hospital no longer exists?

Dr. BERTUCCI. Six feet of water came up in 45 minutes. I was actually there with 54 patients. And 6 feet of water came up in 45 minutes and 1 foot an hour to 13 feet. So this hospital got destroyed that day. 200 evacuees came over the railings and were housed in the center of the hospital in the hallways and all had to be evacuated by boat. The hospital was irreparable, and it is a total destruction, yes.

Mr. BURGESS. Well, let me ask you a question because when I was there obviously you couldn't even get into the area unless you signed a form for FEMA that you wouldn't hold them responsible for what happened to you. Are people repopulating the area now? I noticed they were when we were there, even with those restrictions.

Dr. BERTUCCI. The most amazing thing is we have increased to 25,600. There are 11,000 houses that are being built. We had 28,000 before, but 11,000 according to the newspaper, the last article I saw, are being built. We had 1,400 businesses, now we have 372 and people go, that is not very good. I said, when you started at zero, that is fantastic. We actually now have grocery stores, we have coffee shops, we have restaurants. We have no retail stores to buy clothes still, but people are coming back. The people of St. Bernard were the sheetrock hangers, the painters, the roofers. If they get their Road Home money, they will do this themselves; but they have got to get that money, and right now the Road Home is holding us up big time.

Mr. BURGESS. Let me ask you a question because this is a little different from the Ninth Ward question. This area was hit by the surge or the storm surge, is that correct? Not the levee breaks?

Dr. BERTUCCI. Actually, the water that I saw, and I saw water coming that looked like it came from the industrial canal area, and then we had the break over by Lake Borgne. So there were two areas that flooded. The water that came in did not come as a wave. I saw just the parking lot fill up and then like I said, it gradually rose. I mean, 45 minutes is pretty fast.

Mr. BURGESS. Yes.

Dr. BERTUCCI. But it went up to 6 feet so it wasn't like a wave that came and took the hospital down.

Mr. BURGESS. Do you have a place to rebuild? If you talk about bricks and mortar, do you have a place to build that is higher in elevation or will you have to raise that site up?

Dr. BERTUCCI. Well, in order to coax the hospital back, we actually got 30 acres of land donated that is right on St. Bernard Highway. It is 8 feet higher than the other one. The hospital will be built up. The St. Bernard Highway—we wanted access after a storm to our hospital facility because you need it. St. Bernard Highway in 2 or 3 days and you could drive back and forth all along St. Bernard Highway. So the water receded very quickly. St. Bernard Highway had 5 feet of water. If you build up 8 feet and it is already 8 feet higher than where Chalmette Medical Center is, the hospital should be able to survive any type of flooding situation if they do the levee systems the way they say.

Mr. BURGESS. Well, obviously, the fundamental safety question is one that I think we take very seriously. How helpful has the Small Business Administration been to you when you are on this effort to try to rebuild?

Dr. BERTUCCI. We have a civil group there that does help quite a bit, and they are working diligently with the Franciscans. I am a doctor, and I am trying to do my medicine along with recruiting the funds. So I can't say that Small Business and I have been in contact that often.

Mr. BURGESS. OK. Ms. Rowland, let us talk for just a minute. You referenced right in reference to the chairman's follow-up questions about the snags and facilitation of getting the funds. Now, when we received a number of displaced persons in the Dallas-Ft. Worth area, Secretary Leavitt came and said he was declaring a public health emergency because of the persons who were displaced by the hurricane and that funds would be made available. However, in Texas I know the mayors of Dallas and Ft. Worth have had some concerns because they have difficulty getting the money that has come to the State, they have had difficulty getting money from the State then to filter back to the municipal level. Has that been an issue where you are as well?

Ms. ROWLAND. Well, I think that when we did some evaluation of the waivers that were granted to help the Medicaid patients to be covered and to provide some uncompensated care funds, the funding for that was actually delayed until the Deficit Reduction Act could be enacted to provide the funding.

Mr. BURGESS. Wait a minute. Let us back up for a minute because we passed a supplemental appropriation bill of I think it was \$100 billion during the fall of 2005 after Katrina hit. It was almost like we were force-feeding Louisiana dollars, so I guess I am a little bit—I don't understand why the Deficit Reduction Act is coming into it even because those were monies that were appropriated several weeks before we did the Deficit Reduction Act.

Ms. ROWLAND. But it was actually through the Deficit Reduction Act that the funding for those Medicaid waivers was actually put in place and where the uncompensated care funds were. So it was that that helped fund the services that were received in Texas. And a lot of it is just there were administrative steps that had to be gone through so that individuals showing up at a hospital could be enrolled in the Medicaid program. They had to refer back to Texas, and then a lot of the people who came to your facilities were uninsured people who were not on Medicaid, and that required the uncompensated care funds to flow.

Mr. BURGESS. Yes, separate out the Texas part for now. I am talking strictly of what was happening in Louisiana. Out of \$100 billion that we passed in the fall of 2005, no dollars were available for patient care until we passed the Deficit Reduction Act in January 2006?

Ms. ROWLAND. Well, certainly the Medicaid funds for those who were covered by Medicaid were available and then the Supplemental and the Deficit Reduction Act provided the additional financing to cover the State's share of those funds. So there were Federal funds flowing but additional funds came through the Deficit Reduction Act.

Mr. BURGESS. Do you have any ideas as to the dollar figure of Federal funds that have come to Louisiana? Does anyone on the panel have a concept?

Mr. MELANCON. If the gentleman yields?

Mr. BURGESS. No, in fact, let me get you—you can share that with me later. I wanted to ask Dr. Wiltz before I run out of time about the health centers that you have that are in the pipeline. That 287 was a figure for the entire country?

Dr. WILTZ. Right.

Mr. BURGESS. You have at least 10 that are on line for your area, region 3?

Dr. WILTZ. In region 3 we have four that are pending that right now.

Mr. BURGESS. That are pending? The applications are pending?

Dr. WILTZ. They actually received the initials for in the 90's on the initial applications.

Mr. BURGESS. And how long does it take then for HRSA to respond with funding if you received that high score?

Dr. WILTZ. We are hoping as I said at the hearing, the next few weeks. Now, once we get the funds, we have a mandated time to get up and running.

Mr. BURGESS. Were those applications in process before Katrina hit?

Dr. WILTZ. Yes.

Mr. BURGESS. They were? What is the timeline from when the need was recognized and those applications were initiated to where we are today where we are perhaps on the brink of getting funding?

Dr. WILTZ. Maybe a year.

Mr. BURGESS. Well, Katrina was 18 months ago.

Dr. WILTZ. As I said earlier, we had a Health Care Commission that they had a statewide strategic plan pre-Katrina. So we knew there was a shortage of community health centers in the State already and it put in the pipeline for this expansion pre-Katrina. And then when Katrina hit, all that got put on hold so more recently—

Mr. BURGESS. It got put on hold?

Dr. WILTZ. We had to resubmit it last year.

Mr. BURGESS. That was HRSA's requirement that you resubmit those clinics that you already knew you needed before you had a health care disaster of this proportion.

Dr. WILTZ. I am trying to remember the timeline again, but we get the initial score and then we didn't get funding, I know that.

Mr. BURGESS. I am not being critical. It goes back to the issue of the snags and the facilitation. Again, \$100 billion that we sent from here to you and Mississippi and to some extent Alabama, and where is the help for the people? That is what is frustrating me so much. Has it been more difficult to get those applications processed since Katrina with HRSA?

Dr. WILTZ. I wouldn't say more difficult.

Mr. BURGESS. It was 18 months.

Dr. WILTZ. We transmitted them. I mean, as far as them getting them? No, I think they have gotten them.

Mr. BURGESS. It is 18 months and your mortality rate is twice what it was with half the people, we saw on the video, so I mean that to me would qualify for a sense of urgency.

Dr. WILTZ. Yes.

Mr. BURGESS. If we were ever to have a Federal agency recognize a sense of urgency, it seems that 18 months seems unconscionably long to me, particularly if those applications had already been in process before. Can you identify where it is that this snag is occurring, where this hold-up is occurring? Is it just with HRSA, is it something that is happening at the local level?

Dr. WILTZ. No, I don't think it is at the local level. I think we all recognize that model is one that can work, and we have to get letters of approval and support from all the local folks. So we have gotten those. I don't know why. I could not answer that, where the snafu is.

Mr. BURGESS. OK. Mr. Chairman, I hope we are able to devote some time to winnowing that question down.

Mr. STUPAK. Hopefully the third panel. Next, Ms. DeGette from Colorado for 10 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman. If we can have the map of operating clinics and hospitals put up on the screen?

[Slide shown.]

Ms. DEGETTE. This is my question. We hear everybody—and by the way, everybody here is so dedicated. Some of you I have been working with for a long time, ever since this terrible tragedy; and I am always struck by the commitment of all the health care professionals, in particular the front-line providers, the doctors, the nurses, everybody that is out there. It is extraordinary to see.

But my question is this. In the 18 months since Hurricane Katrina, what we have seen is a number of clinics springing up, and we have heard the success stories of some of them today. Each one seems to be pursuing different sources of funding with varying degrees of comparative success and working together at some level. Maybe I will start with Dr. Franklin with this question. Are these clinics springing up primarily because a need is seen by some group and then the group pursues funding or is there some coordination of these clinics and if not or if it is minimal, could we have better coordination so that the clinics that we are getting are really being used to respond to patient needs?

Dr. FRANKLIN. Ever since I returned from Dallas as an evacuee, we have been working together on a regular basis, sometimes twice a week as a group to coordinate our location based on the availabil-

ity of facilities because remember that we have a number of facilities that were just simply destroyed.

Ms. DEGETTE. Right.

Dr. FRANKLIN. The city of New Orleans, for instance, had more than 10 operating locations and is now down to four. I don't want to speak for Dr. DeSalvo, but I know that Covenant House was a location that was under negotiation early on, had to be worked through in terms of it as a permanent location. So we have spent a lot of time working together to organize the types of services we are going to provide, the communities we are working in, et cetera, et cetera.

Ms. DEGETTE. But it still seems to me that we have huge unmet needs and everything from psychiatric care to chronic long-term care for cancer patients and diabetics and anybody with long-term chronic issues. What kinds of plans are being made to have a comprehensive system that is going to address all of those issues? Dr. DeSalvo, did you want to talk to that?

Dr. DESALVO. I do. We are trying to think beyond tomorrow as you say, and so for example, we are trying to move beyond sharing services like mammography, for example, where he is doing that for us and think about how we systematize what we are doing to create a medical home system of care, not just a bunch of little medical homes that talk to each other.

Ms. DEGETTE. And how are you doing that, Doctor?

Dr. DESALVO. We are doing that through PATH which is our umbrella organization. So it is not a single entity, it is not a governmental agency, it is a not-for-profit agency that is run by the Louisiana Public Health Institute through which we all participate. We have leadership there, administrative leadership, but we don't really have the funds to systematize ourselves. That is an issue which we are working on and sorting that out.

But for example, sharing health information about patients so that if a patient is at Vanges Clinic normally and works maybe near my clinic and needs to pop in to get a follow-up, I can access that record and the patient doesn't have to go back to the clinic by their home. So really, we are making it easier and more accessible for the patients.

We are also working together to begin to measure how well we are doing care, what is the quality of care, how acceptable are we so we have some idea of where the gaps are and how we could improve.

And then we estimate. For example, we are running some numbers we think that based upon the number of uninsured in the city that just for that population alone we need to add another 30 physicians or so to get up to about 66 physicians. And we are putting some price on that and trying to sort that out. Where would we find that money and how could we grow together?

Ms. DEGETTE. Doctor you wanted to add to that?

Dr. BERTUCCI. Right now we are trying to set up medical homes in our clinic also. Of course, with three and now soon to be four physicians, that is extremely difficult. Part of the problem is that we are not computer savvy, so we have four physicians to treat 25,000 people. That comes out to one doctor in about 5,000 people. So it is kind of hard to learn to use a computer, and the computer

actually slows us down initially because it is a 2-year learning curve for this. You are going to slow down five to seven patients a day. And with that it is difficult for us to incorporate it when you are the only doctors there. Where do we send those five to seven patients that we are not going to be able to see?

But we did partner up with LSU as far as trying to get some specialty help. At least they are trying to. This is the plan, that we are doing investigations for a medical home, we are trying to get a computer system and we have some specialists to back up if we can do that.

Ms. DEGETTE. Dr. Fontenot, do you want to add to that?

Dr. FONTENOT. Just to say that we have as the PATH group surfaced sort of as the primary care group with its hospital partner which historically has been Charity Hospital. But we do include mental health providers and to provide true medical homes, we are coming up with the same idea which is to look at outcomes. Funding needs to follow the patient, but it really needs to be predicated on outcomes and accountability. And I think the group of people you see here in front of you, including Dr. Bertucci, are really intent on proving that we are providing quality care.

Ms. DEGETTE. Dr. Fontenot, I wanted to ask you another question. I have got an article from Times-Picayune called "Hospitals Run Out of Space, Emergency Room Patients Wait Hours for Beds to be Available". And this article is from last week. I mean, it is not like from a month after the hurricane. And it says things like Jack Fin says we are in crisis in New Orleans, there is not a bed anywhere in the city, that it is getting worse. As soon as a bed opens up it gets filled. I wonder if you can talk to me why this is still going on and why it is getting worse?

Dr. FONTENOT. Well, in my humble opinion, part of the problem is lack of access to primary care. Many of our patients are showing up at our emergency department and our hospital sicker with chronic medical problems because they have lost access to their primary health care and primary care provider. So part of the problem is certainly a lack of access to primary care. We are trying to be part of the solution to that, actually initiated our own primary care clinics in November 2005, have had some FEMA reimbursed trailers sitting on our parking lot because of local bureaucratic red tape that are intended to be placed in community settings as temporary at least but to increase primary care access. These guys have been doing a yeoman's job and doing the best they can, but they are certainly at capacity; and I think if there is one thing we could do immediately is open up additional primary care. But the second step for that is when Dr. Bertucci identifies a cardiology problem or an oncology problem, he has to have a place to send those patients. And so specialty access is almost as important or equally so.

Ms. DEGETTE. Yes, Dr. Bertucci?

Dr. BERTUCCI. I think the one other thing is that as we see them in the physician's office, instead of them going through the emergency room, we can make them direct admits. We can do a history, physical, write the orders, and have that person admitted. Sometimes it is just for observation. But we can alleviate that emergency room admission so to speak by directly admitting them to the hospital for observation with a specialist that we have contact with.

It is difficult. I mean, we see very, very sick people right now. These are not the normal people that we were seeing. The physicians, the primary care doctors, we are out of our element a little bit in what we are handling; but we are doing it because we are the only people there. And when you go to send somebody to a specialist, whether it be a bladder doctor, an orthopedist, whatever, they are not there. You are talking about a 30- to 60-mile drive; and we need to set up some type of coordinated system to get the specialist back, along with the primary care, so we can do the medical homes, we can do the electronic medical records, et cetera.

Ms. DEGETTE. Are you all working under some kind of a jointly—I know there was a plan developed which was submitted to Secretary Leavitt and then he kind of rejected it and said he wanted to go to this insurance program. But other than that, is there any kind of long-term plan that you are all operating on to—it seems to me what we need to do, we need to fully develop the primary care system so that people don't have to wait in line. Then we need a whole system of specialty care for folks so they can have a place to be referred, and then we still need to—and I am going to talk about this with the next panel—we still need to get a safety-net hospital system in place in the absence of Charity. So with all of that, is there some kind of plan to do that, Dr. Fontenot?

Dr. FONTENOT. Yes, I believe there is, and I think you have described it quite articulately because you need the primary care, specialty care, you need hospital partners to provide the hospital-based services, the expense of MRIs, the CAT scans, the surgical procedures that need to be done. And I think that with PATH as a chassis that we can certainly build on that and go forward. But we are certainly planning, have been, even prior to the storm actually the PATH group existed. I have to tell you at that point, it was a much looser coalition with different agendas. I think that one of the bright spots of the storm is that it has caused a coalescence I think of a group of those of us who are committed to provide services to this patient population.

Ms. DEGETTE. And just one last question. Do you think that the primary thing the Federal Government can do is provide the funding streams that you have all talked about or do we also need to break some bureaucratic and regulatory barriers as well to help you realize that plan?

Dr. FONTENOT. I think you have hit it on the head. I think additionally is to try to help figure out some incentives and recruitment. I know that Dr. Cerise will probably be talking later today about recruitment efforts and how we can increase that because you will hear I think a person on this panel that we really need providers.

Ms. DEGETTE. Thank you.

Dr. WILTZ. Can I summarize that? Local problems deserve local solutions by local people using Federal money, if you can send it.

Ms. DEGETTE. That is not always the way the Federal Government feels, but thank you for sharing your view.

Mr. STUPAK. Mr. Ferguson, 10 minutes, please. Dr. Bertucci?

Dr. BERTUCCI. I have to say this or I can't go back to my parish. When you asked about the storm surge, the MR-GO was one of our

biggest problems, and obviously that is being addressed. If I don't say that, they won't let me back in that parish.

Dr. FONTENOT. Then you will only have three doctors.

Dr. BERTUCCI. Then we will only have three doctors, you are right. So I just want you to know, we are working on that issue. The storm surge that came, our levee system on the MR-GO was 18 feet, supposed to be, high. Of course, erosion had made it some 15. The wave that came through the MR-GO was 21 feet high. Now, what happened was that wave came, yes, there was a storm surge, but eventually it eroded through our levee system. Thank you.

Mr. STUPAK. Mr. Ferguson for 10 minutes.

Mr. FERGUSON. Thank you, Mr. Chairman. I want to thank all of our witnesses for your testimony today and your work to shed some light on some of the challenges that we all face together with regard to particularly the health care challenges post-Katrina. I, like many, many other people, had an opportunity to spend several days over that Labor Day weekend following the storm just volunteering. We spent our time in Baton Rouge where so many of the folks had been brought out. We actually worked in a First Baptist Church in Baton Rouge where many moms and their newborns who had been airlifted out of the city were brought and there was—we have four little ones at home, so it was a nice opportunity to help some folks with their newborns and their little children and their families.

We also did some work at the River Center Shelter just distributing clothes with some of the Red Cross volunteers. But it really, for me just thinking back, just to that personal experience, highlights really some of the health care challenges that you all are working to try to help solve; and I appreciate you sharing some of your experiences with us today.

I just want to pick up on a couple of comments that a couple of my colleagues here have made and questions they have asked, and I wanted to ask Dr. DeSalvo, if you could perhaps elaborate a little bit further on the concept of the medical home. I know Ms. DeGette talked about this a little bit, and I am familiar with some of what you talked about in your testimony; but could you maybe expand on that a little bit further and maybe talk about specifically what you are doing at Tulane with regard to this concept, this medical home concept?

Dr. DESALVO. Medical home has actually become a buzzword in health care nationally at a time when we needed something like that to describe what we wanted to do post-storm. Before the storm we all really had an approach to this through the hospital-based care and very siloed care. So physician, and then you needed mental health, and then you referred elsewhere.

A medical home is really a change in that approach. It is an approach to care where multidisciplinary teams that are generally led by a physician have a relationship with the patient. And so the values that that medical home has for things like patient-centeredness which includes cultural competency but also quality and helping patients self-manage their chronic disease and then using health information technology to support care. So to share health information with all the other providers, taking care of that patient, with

the patient themselves so they can understand their medical issues, and then to do things like clinical decision support so that if we forget to order something that is evidence based and preventive, the computer if you will helps us remember and work with the patient to make them better. So it has some essential components of team-based care management supported by health information technology, and it also encompasses this idea that it is very accessible to the patients; and for us in New Orleans, that definitely means geographically accessible, hence the map. We have been using these maps since the early days to really visually see where we actually have placed care in our city, where the lights are coming back on and people are coming home, and where we think we might need to put new medical homes. It is insufficient by itself. They have to be linked to each other and then to secondary level care, specialty care, and then to a hospital when necessary. But it really should be the multidisciplinary entry point for the patient into the system.

Mr. FERGUSON. Chairman Stupak was talking a little bit before about the funding that is available through the Deficit Reduction Act and that some of those monies are still there. They are sitting there, they are not spent yet. In your estimation, what things can we be doing to help folks like you and your colleagues access some of these funds?

Dr. DESALVO. On our back-of-the-envelope calculations that we have been doing at home, we think there is sufficient money in the Deficit Reduction Act's allocation, and there is a category 5 the GAO reports about which is—at least when the report came out was about \$136 million that could be used to restore health care services, but I don't have any policy experience. It seems to me that that is a sort of bucket of money we could use, and it would go a really long way because primary care is incredibly inexpensive. And that sort of money has already been allocated if you will and there are already providers over here trying to do the right thing, and we just need to put them together. In fact, we even have the mechanisms for the money to flow because of the SSBG, the Social Services Block Grant. We spent many months making contracts and relationships from the HHS to the States to a quasi-governmental agency which then allocated it to the PATH network through the LPHI so that each of the clinics could then benefit from funding based upon a pretty rigorous budget that we put together. So there is already a mechanism through which we could allocate those funds.

And if I could, I think the idea is if we don't do that, if we don't provide some bridge support for these clinics, we are going to go away. We are going to crash. And then we are going to go back to a system that was not working well for us which was using a lot of emergency rooms for care. And so it is a really important opportunity.

Mr. FERGUSON. It also seems like you have got a model that seems to be working. We have some funding available which could help it work, continue to work well. It would be tragic if we couldn't get our act together here collectively. Did you want to add something to that?

Dr. BERTUCCI. Yes. I saw a sign and it said get well soon. And it said, we prefer, stay healthy longer. So I think that preventative medicine is a big thing.

The only problem I saw with the medical home because I am a dinosaur primary care doctor who was raised by, see a patient, make some money, see a patient, make some money. And it is hard now to break into the system that the idea of this is that you are not paid by patient contact but by outcome, by trying to prevent the patient from coming in the hospital. You save money, everybody makes more money. It is difficult for me to conceive.

The second problem is that primary care doctors, we are people doctors. We like seeing patients. If somebody sat there and said you don't have to see 40 patients anymore, I would say, I like seeing 40 patients. I mean, I like people and I like patients. So it is hard for me to delegate that out to other ancillary people, but that has to be learned.

You have an opportunity now as you change the medical schools and everything else to train these people number one, with electronic medical records. I never used the computer until the hurricane, and I am much better at it. I actually made a power point but I got it here too late. But you can learn. We are teachable, OK? But the students come and these are the people that you have got to teach these concepts if you want them to work. The only thing I fear and let me tell you, I am a firm believer in patients taking responsibility for their illness; and when you get so many ancillary people involved, sometimes I worry that the patients start to depend on them and not take responsibility for their disease. So that is just something we can watch and we can learn, too.

So I see a good benefit to the medical home, I see a great benefit to the electronic medical record, and I think it will work but we need to really start with a training situation and bringing the people out and training the primary care as they come in.

Ms. ROWLAND. Mr. Ferguson, I think it is important to note that while everyone is talking about building capacity, putting community health centers in, that those centers rely on financing and ultimately just sending appropriated dollars to run those centers isn't what keeps them going. What actually keeps them going is to provide health care coverage that some of the patients in those centers actually have health insurance paying for their care.

Today the average community health center receives more of its revenues from the Medicaid program than from the Public Health Service Grant dollars because they are seeing about three-quarters of their patients with Medicaid coverage and a quarter who are uninsured.

So I think looking at the Louisiana situation as just an issue of putting public health resources on the table is not going to sustain these clinics over the long run. They really also need to address their tremendously high rate of uninsurance.

Mr. FERGUSON. I have got a minute-and-a-half. Go ahead.

Dr. FRANKLIN. The short term issue is so critical, I would like to remember everyone in this room the importance of the short-term issue. Our health fairs would not have been such a success, Operation Blessing would not be as busy as it is unless we had thousands of people who needed health care today, tomorrow, the next

day. So a one-size-fits-all solution is not where we need to be today, tomorrow, and the next day.

Clearly we have all worked to goals to improve our ability to respond to outcomes, provide information regarding outcomes, et cetera, but you can see before you a number of different types of health care providers, different times in our careers, different skill sets in terms of providing the care to patients, different solutions for different organizations.

And so I would like to emphasize to this committee just having a community health center approach is not enough. We need all levels of approaches to the solution.

Mr. FERGUSON. Thank you very much. I yield back, Mr. Chairman.

Mr. STUPAK. Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman.

Mr. Koehl, you indicated in your opening remarks that you have seen a 48 percent increase in the death rate in New Orleans.

Mr. KOEHL. Those numbers come from Dr. Kevin Stephens' office, a 48 increase per capita in the death rate post-Katrina.

Mr. WALDEN. Now, I guess the question that comes to mind is a lot of people fled New Orleans and did not come back. Is part of the reason there is a higher death rate is those who were sickest couldn't leave and are there? I mean, what are the contributing factors? That is such an astounding increase in the death rate.

Mr. KOEHL. Lack of primary care seems to be the major issue, and without the lack of primary care, you don't have a doctor a year ago telling you that you had high blood pressure.

Mr. WALDEN. Right.

Mr. KOEHL. So what happens is you present yourself in a clinic situation with a heart attack when a year ago one prescription of a diuretic possibly and another hypertensive medication would have prevented that heart attack. So the lack of primary care for the last 18 months has exacerbated this problem greatly.

Mr. WALDEN. So the makeup of the population has remained similar?

Mr. KOEHL. For the most part except this population is now uninsured and doesn't have anywhere to go for primary care.

Mr. WALDEN. They don't have the access.

Dr. BERTUCCI. I think the other thing you have to realize the amount of stress these people were living under.

Mr. WALDEN. I can't, no.

Dr. BERTUCCI. Stress will exacerbate every disease entity you have got, whether it be diabetes, coronary artery disease, it makes no difference. As we loaded people off the roof of the hospital into the boats, they didn't say boo. When we put them in helicopters, they were all in shock. And as you sit and see patients now, even the stoic patients—I mean, these are guys that worked in business offices, lawyers, everybody, they are getting depressed because they are exhibiting what I call emotional fatigue.

Mr. WALDEN. Sure.

Dr. BERTUCCI. They used up all their reserve energy and now they can't handle and cope anymore. So I think stress is a big, big part besides lack of access to care. Stress and dealing with everything that—they have got to deal with insurance companies, they

have got to rebuild their homes, they have got to get a new job, they have got to handle—all their families are displaced. When you sit down with a family, all these families live together now. You go and you say, well, where is your mom? Well, they all moved. They are all over. I mean they are in four different spots when they used to be within two blocks of each other.

Mr. WALDEN. I had to step out of the room for a few minutes, and I don't know if you answered this but you raised an issue, Dr. Bertucci is it about your inability to get an SBA loan. Why? That is what I don't understand.

Dr. BERTUCCI. What had happened is my partner would not come back. So when I went to the SBA, they said, well, your partner has to sign that he will take the SBA loan, too. I said, well, he is not coming back. And I said, so what do I do about that? I had to go get his name removed and everything else. Then when I reapplied, again this is what I was told. I am not a bad credit risk. I was number one. I don't owe any money, and sometimes these SBA loans are forgiven. And I said, well, I don't want it forgiven, I just want a low-interest loan so I can rebuild my office. And this has been five appeals worth and the papers must be this high. We have jumped through every hoop that they have asked us to do, and we don't have that money.

Now, I am working with the Franciscans, and I am very happy with them so I don't want them to think I am going to go build an office and move away. But the reality, and I am sure other doctors are going through this same situation, and we need that monies and we also need some monies for people that weren't there before the storm that may want to come back, some low-interest loans to help them build a building, not just the ones that were there before. And they need to speed it up. The red tape is a killer.

Mr. WALDEN. I guess that is what stuns me in the course of this hearing today is the fact you still have people, I assume from these videos, that are showing up the night before or 5 in the morning or whatever and waiting in lines and yet don't I recall that there was a lot of money sent out before the DRA for DSH payments like to Charity Hospital? I think Dr. Burgess indicated it is like a quarter-of-a-billion dollars was sent to Louisiana? What has happened to that money to help in this?

Dr. FONTENOT. Well, remember that the DSH money that flowed to the hospital only flows if service is provided, not a free check.

Mr. WALDEN. I got you.

Dr. FONTENOT. So having been out of the hospital business for a period of months, immediately post storm we reopened clinics, started the tents that you saw in the parking lots, and talked with CMS about whether there would be some reimbursements because these are not licensed facilities.

Remember, we have never been through this before. These were medical tents.

Mr. WALDEN. Hard to have joint commission come and do their evaluations I assume?

Dr. FONTENOT. Exactly. Then we actually got back into the inpatient business temporarily for the trauma facility and a leased facility in an adjacent parish and actually just opened portions of University Hospital in November. Some of those DSH monies now

over the last year have flowed to other hospital institutions who have been providing care. So there has been DSH money flowing, it is just not all been directed to the public hospital system.

Mr. WALDEN. OK. And I guess what I would like to sort out, too, I mean, we have obviously voted to send a lot of money. I have. I am from Oregon. We don't get hurricanes thankfully. We have forest fires and a few things, but they are not as devastating to people and communities generally. I guess what I am trying to figure out, we have allocated a lot of money. What sort of impediments do you have to be able to access that and do some of those—are there issues like that the State needs to do something, ask for something that are holding up distribution of the money?

Dr. FONTENOT. I think that in panel 3. Dr. Cerise is going to be speaking to you about that—

Mr. WALDEN. All right.

Dr. FONTENOT. And that probably would be better left to him for discussion.

Mr. WALDEN. So none of the rest of you have any ideas on that? Dr. DeSalvo? You are smiling. You just don't want to say. Dr. Bertucci maybe?

Dr. BERTUCCI. I think that we need more access to the Louisiana Recovery Authority so that we can get some of our community block grant money for buildings and structures. The infrastructure seems to be a taboo. Everybody says don't ask for this, don't ask for that. You are asking us what we need, and so we have said we need funding and we need buildings and we need a hospital in St. Bernard. The infrastructure, when you come to buildings, brick and mortar, everybody goes don't do that—

Mr. WALDEN. But if we get back to what Dr. Fontenot said, you don't get DSH payments without a facility in effect, right? So you don't get the money to pay for the services if you don't have the bricks and mortar for the physicians to come back to and the nurses and everybody else that we need. Seems to me the first thing you do is establish some sort of physical facility so you can call it a hospital and then be able to practice medicine. You know, we do this in other emergencies around the world. If it is tents, it seems like you would call out the National Guard. I don't know.

Dr. FONTENOT. Or begin to allow DSH money to cover formerly unallowable costs, specifically physician costs. Those historically have not been covered for the public hospital, nor for any other health care provider. So that certainly is an option.

Mr. WALDEN. OK. Ms. Rowland?

Ms. ROWLAND. You know, often it sounds like the DSH program is a block grant which has flexible spending under it; but the DSH program actually was set up to provide additional payments for public hospitals when the Medicaid reimbursement formula was changed. So it has to be at least linked to direct-patient care. And I think you are right that one of the things we could look at as a better way of dealing with emergencies such as this is to have some more flexibility in terms of how quickly DSH funds could be reallocated. But the real funds that we keep talking about are discretionary, both the Social Services Block Grant and then in the DRA there were additional funds set up that were discretionary funds that could have been used.

Mr. WALDEN. And where are those monies now?

Ms. ROWLAND. Those have not yet been expended according to the recent report that just came out from the GAO. Those funds have been set aside and not yet expended.

Mr. WALDEN. By whom?

Ms. ROWLAND. By the Department of Health and Human Services.

Mr. WALDEN. So DHS has those monies that we authorized, and they have not gotten to Louisiana?

Ms. ROWLAND. It was \$2 billion and they used about \$1.5 billion to allocate out for the Medicaid waivers that were given to the States where people were evacuated to and to Louisiana itself, but they also had a section V they call it which allowed for grants to be made to develop access to care and resources, and those have not been fully expended.

Mr. WALDEN. \$1.5 billion of the \$2 billion has been?

Ms. ROWLAND. And those were paying for the medical care costs of individuals either on Medicaid in Louisiana, Mississippi, Alabama, and the evacuees or for uncompensated care in those States.

Mr. WALDEN. OK. One final question because again, I get asked this stuff in my district and I have supported the emergency relief and all. But one of the questions that consistently comes up is, are you spending our tax money to rebuild buildings that are going to get blown away in the next hurricane or flooded out? What is the answer I should give? I know at Charity Hospital I think I heard this morning that—or maybe it was you, Dr. Bertucci, that said somebody was offering ground that would be 8 feet higher but don't I recall the flood of your building was 13 feet? So you are still 5 feet under water.

Dr. BERTUCCI. Well, yes. Actually what is going to happen is it is 8 feet higher, and the hospital will be built up 8 feet. So you are talking about 16 feet. So I think that is No. 1. Second, the floods that have occurred, if you look, obviously are on a 40-year type of a term. Well, you had the what, 1927 flood, rise in tide. You had Betsy in 1965, and then you have Katrina. I am not saying that we don't want to prepare for that, but the reality is that we can—if they fix the MR-GO—we didn't flood from the hurricane, we flooded from the levies breaking. So if we could fix the MR-GO, raise the levies up to what they said they were going to fix, we should be able to weather those type of storms. Now, there is no guarantee. That is why I think it is hard to recruit people to this area, number one, to live in what were are living in, two, to practice in the situation we are practicing in. Without facilities, it is impossible. The people, though, amazingly, multigenerational, they want to come home. And with the hospital you are going to get your elderly people back, you are going to get your specialists back—you can't get the specialists without the hospital and without the old people, I mean, nice old people.

Mr. WALDEN. Mr. Chairman, I know my time has expired. I just wanted to say thank you for what you do in your communities. The commitment you all must be adhering to is hard for us to really fully appreciate I think unless we were on the ground there. So thank you and your colleagues for what you do to try and improve

the health care and the lives of the people of Louisiana and the Gulf Coast. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. Mrs. Blackburn, I understand you want to pass on this panel until next panel? One question? Go ahead.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and I want to thank all of you. I appreciated the attendance and the interest when we did our first hearing in Louisiana last year to follow up on this issue. And Mr. Walden was on the line of questioning where I want to go, and I do have questions for Dr. Cerise when he comes about the funding. And I want to clarify that I am understanding right. Ms. Rowland, you are saying \$2 billion was appropriated, \$1.5 billion has been spent?

Mrs. ROWLAND. Well, \$1.5 billion was actually allocated out and the States are filing claims against it, so it hasn't totally been spent but it was allocated to the States.

Mrs. BLACKBURN. All right. And the section V money is not fully expended is what you were saying?

Ms. ROWLAND. Correct.

Mrs. BLACKBURN. OK. I wanted to seek clarification on that, and then Dr. Bertucci, I think you said the LRA, you all were having trouble accessing the funds via that?

Dr. BERTUCCI. Actually I met with the LRA subcommittee, and again I am not supposed to get controversial but what I was told was that medicine was not a priority when we met. They sat down and a survey in the beginning of the hurricane and said, what are the needs? What would make you come back?

Mrs. BLACKBURN. OK.

Dr. BERTUCCI. Now, what made them come back were levies, jobs, housing. So that is very important. So they did put those ahead of us—police, schools, churches, fire, medicine. So we were told as we met that the reason that we had not been there was that medicine was not a priority. Now, I am assuming we are a priority now, and I am hoping after this meeting we get some access to them. The problem comes that we are being told now that maybe the infrastructure monies that they had were already delegated out to other hospitals and different other situations.

And I want to say one thing real quick. Thank the United States of America and all of you and everybody who sent donations down here to help us through this. Louisiana greatly appreciates it.

Mrs. BLACKBURN. OK. And then of you all who are practicing medicine, how many of you are practicing in a brick-and-mortar facility? OK. All right. And then the Operation Blessing, is that in a brick-and-mortar yet?

Mr. KOEHL. No, it is not.

Mrs. BLACKBURN. It is not? OK. So that is still in a temporary or a tent?

Mr. KOEHL. No, it is mobile units brought together—

Mrs. BLACKBURN. In the Wal-Mart?

Mr. KOEHL. No, we are not in the Wal-Mart.

Mrs. BLACKBURN. OK.

Mr. KOEHL. We are East Orleans on Reed Boulevard.

Mrs. BLACKBURN. All right. Thank you.

Dr. DESALVO. Mrs. Blackburn, for clarification, our clinic was a men's dorm that we are renovating. It is not really a clinic though we are in it and we have air-conditioning.

Mrs. BLACKBURN. Now, has the Health Care Authority in Louisiana going to change their process on how they permit? I know they were giving permits even though you all had your generators and your storage in the basements, and they were not supposed to be doing that. They were supposed to be on the fourth floor. Have they changed the way that they are going about giving the permitting? Does anybody know?

Dr. WILTZ. The State enacted a new building code to all new construction, so all new construction has to meet—

Mrs. BLACKBURN. New construction, right?

Dr. WILTZ. Yes.

Mrs. BLACKBURN. OK. Thank you for that.

Dr. FONTENOT. At Charity Hospital it is important to remember that our switchgear is still in the basement. FEMA will not allow you to rebuild anything that is not out of the flood plain without mitigation, et cetera. But they do require with our repair of University Hospital back to its previous status that we provide some asset protection which will include a little flood wall to keep water from getting into the basement. But again, they only allowed that because it is considered a temporary facility.

Mrs. BLACKBURN. OK. I know the State of Louisiana was self-insuring. Have they changed that process so that they are no longer self-insuring their infrastructure? Dr. Wiltz, do you know that? If not, I will ask Dr. Cerise on panel three.

Dr. WILTZ. No, I do not know that.

Mrs. BLACKBURN. Nobody knows? OK. Thank you, Mr. Chairman.

Mr. STUPAK. Thank you. On behalf of the full committee, thanks for being here today and helping us out. We look forward to continuing to work with you. This will not be the last hearing. It will not be a year. We will keep the pressure on, and you will be seeing a lot of us. Thank you for coming.

Dr. WILTZ. Thank you.

Mr. STUPAK. We are looking forward to hearing from our next panel. Dr. Alan Miller, interim senior vice president for Health Services, Tulane University Health Sciences Center; Mr. Gary Muller, president/CEO, West Jefferson Medical Center; Dr. Pat Quinlan, CEO, Ochsner Health System; Mr. Leslie Hirsch, president/CEO, Touro Infirmary; and Mr. Donald Smithburg, executive vice president/CEO, Louisiana State Health Care Services Division. If those folks would please come forward?

Gentlemen, as you know, this is Oversight and Investigations hearing of the Energy and Commerce Committee. We swear-in all of our witnesses.

[Witnesses sworn]

Mr. STUPAK. Thank you. The witnesses are now sworn. We will start with Dr. Miller. We have your testimony. If you would try to summarize it there in 5 minutes that would be of great help to us, and thank you for being here.

**STATEMENT OF ALAN MILLER, PH.D., M.D., INTERIM SENIOR
VICE PRESIDENT FOR HEALTH SERVICES, TULANE UNIVER-
SITY HEALTH SCIENCES CENTER**

Dr. MILLER. Thank you for the opportunity to speak about the state of health care in the New Orleans region 18 months after Katrina, and Tulane University's role in the recovery.

Since Hurricane Katrina, we have seen enormous progress in some areas, in other critical areas we have seen shockingly little progress resulting in a stalemate that will make reform more difficult and threaten the existence of our training programs.

I want to thank the committee members for your support for the region. I am Alan Miller. I represent Tulane University, an institution of higher education that not only provides health care but also trains our future doctors. The past year-and-a-half has been challenging for everyone in New Orleans, especially those of us trying to rebuild the broken health care system, provide care, and train physicians. Tulane University Health Sciences Center suffered losses of greater than \$200 million in property damage, lost research assets, and revenue. Through the storm and since, Tulane, the largest employer in Orleans Parish, has continued to do exactly what it has done since 1834, provide health care, educate physicians, and advance medical knowledge.

When Katrina struck, it left our medical students, residents, faculty, and staff scattered across the country. In 3 weeks, a medical school for Tulane students taught by Tulane faculty was up and running at the Baylor College of Medicine, and our residents were placed in training sites in Texas, Louisiana, and throughout the country.

By July 2006, there was a 51 percent reduction in the total number of physicians filing claims in region 1. Loss of clinical faculty at Tulane and LSU not only decreased the available physician workforce but reduced the clinical faculty needed to teach future physicians. With the public hospitals down, care for the uninsured has been assumed by private hospitals and physicians. State Medicaid DSH has historically been directed to the safety-net hospital system. With the closure of Charity, there remains a major gap in funding that care. Since Katrina, Tulane faculty has provided \$6.8 million in uncompensated care, and we have absorbed \$5 million in unreimbursed training costs. Despite this, Tulane has retained faculty by guaranteeing salaries through June 2007. In effect, a private, non-profit educational institution has been using its impaired and limited financial resources to underwrite health care and graduate medical education and help preserve the health care workforce. Tulane cannot continue to do this and survive.

In order to preserve the physician workforce, we need immediate funding for providing care. Approximately \$30 million per year is needed to provide basic reimbursement to area physicians for uncompensated care. We ask that you consider a mechanism to provide funding directly to providers. We ask that Congress consider a grant program to provide incentives to recruit clinical faculty to teaching institutions in the hurricane-affected region, for loan forgiveness, relocation, and bridge funding.

Additionally, there must be a focus on the future of GME. This is a long-term issue but requires immediate attention. Teaching

faculty and residents provided a large portion of the care for most underinsured patients in the U.S. Moving medical education to the front burner of health care redesign is critical. Some look at medical residents as moveable parts that could be rearranged to maximize CMS reimbursement. This is far from the truth. Issues of program interrelationship, critical mass, and quality educational experience must be considered or accreditation will be at risk.

Pre-Katrina, Tulane trained 520 residents. At any one time, 240 of those residents were on rotation at Charity. Today Tulane trains a total of 327 residents. Special CMS waivers were required to allow residents to continue their training at new sites. Protracted negotiations took place requiring Tulane to hire outside counsel simply to navigate the process. This should not be allowed to happen in future disasters.

Katrina revealed a major flaw in the way we fund GME. When Katrina hit, the medical schools were left with the responsibility for resident-in-training and salaries but were unable to seek reimbursement from closed hospitals and most cases the hospitals that accepted them.

For the protection of all but most critically that of the trainee, medical schools must have greater control over both training and funding when a disaster results in total or near total closure of a teaching hospital. We ask that the committees consider a hearing to specifically deal with the issues surrounding GME. In addition, Tulane offers to host a panel of all stakeholders to re-evaluate resident training and financing when disruption of training occurs.

Of critical importance to our medical schools is the New Orleans VA Hospital. Pre-Katrina, Tulane faculty and 100 residents provided 70 percent of the patient care at the VA. Outpatient clinics have reopened in the downtown location where there are 26 Tulane residents and visits are up to 75 percent of pre-storm. It is essential to re-establish a hospital in downtown New Orleans. Veterans have expressed a strong desire to have their care resumed by their physicians and the system that has served them well. The facility must remain proximal to the medical schools so that highly skilled Tulane and LSU physicians can provide state-of-the art care.

The gridlock we find ourselves in is destructive, both short and long term for our hospitals, medical schools, and the public we serve. The time has come for all to set aside their differences, share vital data, and have an objective party lead constructive negotiations.

We have many challenges to overcome. With the support of the American people and leaders such as yourselves, we will recover.

Thank you again for your time and support.

[The prepared statement of Dr. Miller appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Dr. Miller. Mr. Muller, please, for 5 minutes.

**STATEMENT OF A. GARY MULLER, PRESIDENT/CEO, WEST
JEFFERSON MEDICAL CENTER**

Mr. MULLER. Mr. Chairman and members of the committee, I am Gary Muller, president and CEO of West Jefferson Medical Center. I am grateful the committee has expressed a continued interest in

the worsening state of the health care system in the New Orleans region.

West Jefferson Medical Center, located 10 miles from downtown New Orleans, is a 451-bed public community hospital and health system with programs and services across a complete continuum of care. West Jefferson was one of three hospitals that did not close after Hurricane Katrina and is now one of the eight safety-net hospitals serving all patients.

Pre-Katrina we were projecting an \$8 million profit in 2005. When I testified before this committee January 2006, we had incurred operating losses of \$30 million. I come to you this time with a heavier burden of \$48 million in operating losses.

Recruiting nurses and physicians has become a near impossibility, and the supply and demand of the entire health care workforce has reached a crisis. Prior to Hurricane Katrina, we spent a total of \$2 million annually on agency nurses. Currently we are forced to spend \$1.1 million each month which was \$13 million in 2006. It is extremely difficult even to have a physician visit our city for the possibility of working there.

Certain financial commitments are necessary to sustain hospital operations in our area. The 2007 Wage Index update that was effective October 2006 was based on wage data from Medicare Cost Reports beginning during fiscal year 2003. Thus, there was almost a 3-year lag between the data being used to develop the wage index and the actual implementation of the wage index that incorporates the data. Under the CMS methodology for incorporating changes, our index will not begin to reflect the changes we have experienced in labor costs until October 2008. I am requesting that you consider a special wage index adjustment for hospitals in the affected area to help offset some of the losses.

West Jefferson is supportive of the CMS Medicaid proposed rule on intergovernmental transfers and certified public expenditures. As we understand the proposed rules, CMS will require States to direct Federal funds directly back to governmentally operated health care providers. This certainly seems aligned with how the Federal Government intended these funds to be used in the first place. For West Jefferson, we believe this will result in equitable distribution of funds directly to our hospital without going through the State. We worked diligently to offer language to the Stafford Act that would qualify hospitals as eligible recipients of the community disaster loan program. With hard work of our entire delegation, we were successful in securing that funding. It was vital for our hospital in the few months following the storm, and we incurred substantial financial losses.

Both the House and Senate appear to be on the verge of floor action to permit the forgiveness of CDL which has been the practice pre-Katrina. I strongly ask for your support to give these loans their currently obligated payback and we cannot do that.

We have implemented an operations improvement action plan whereby approximately \$8 million of savings or revenue enhancements have been identified at West Jeff. Most of the cost savings center on reducing agency nurse costs which included only two nurses pre-Katrina and grew to 92 agency nurses that we employ presently. We have also improved efficiencies so that the emer-

gency room can flow better with the increase in patient volumes. West Jeff also supports two federally qualified health centers in our service area to support the medical home model that you have heard about earlier.

One day last week, we were simply overwhelmed with 32 admissions waiting in our emergency department. Simply put, every available bed in our hospital, which was 55 more than pre-Katrina, was occupied; and we had 32 admitted patients waiting on stretchers in the hallway of the emergency department. Our ambulances and our paramedics routinely wait with these patients which takes these guys and ladies off the streets to serve the patients in need.

Unfortunately this is quickly becoming the norm as there are simply not enough staffed beds in the New Orleans region to care for the volume of patients. We put in a phone call to the Department of Health and Hospitals, and the next day the Secretary, Dr. Cerise, was at our hospital offering assistance and potential solutions. He has also been helpful with his support of the uncompensated care pool that was developed at the State level to offset some of our growing indigent care costs. He is also responsive to West Jefferson's plan to open 12 more mental health beds by funding them. Nevertheless, the shortage of beds, particularly psychiatric and acute care, is at a critical point; and more funds would allow us to open more beds.

However, I remain optimistic that our issues will eventually be resolved by both public and private hospitals, community clinic providers, payers, and governmental officials at the State and Federal levels to provide a united solution in the new model that will improve care for all citizens of Louisiana. I have great faith that our Federal and State leaders will not abandon us. Together we can make a difference.

Thank you very much for your time and your interest.

[The prepared statement of Mr. Muller appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Mr. Muller. Dr. Quinlan.

STATEMENT OF PAT QUINLAN, M.D., CEO, OCHSNER HEALTH SYSTEM

Dr. QUINLAN. Thank you, Mr. Chairman. I want to thank you and the committee and other Members of Congress who have actually come to New Orleans. You have to see it to begin to understand it. Seeing is beginning to believe. I want to remind everyone, whatever you have seen, you have only seen a small part of it; but we appreciate your interest.

Particularly after speaking with your staff, I think this effort will make a difference; and I personally am very hopeful. There is much to be done. Many people have worked together to answer the kind of questions that you have raised here.

I would like to tell you a little bit about us. We are Ochsner Health System, an independent, non-profit organization made up of seven hospitals and 32 clinics, employing about 8,400 people. We are the largest private employer in the State of Louisiana. We have as a result borne much of the brunt of this storm. It is also of historic interest I think for you to know that Alan Ochsner, our name-

sake, made the first connection between smoking and lung cancer; and for that he was ridiculed by the medical establishment.

We are one of only three hospitals. Our other two sister hospitals in Jefferson Parish took care of the patients during the storm. We have been on the point since the beginning. We have done this despite ongoing interruption of our care during and after Katrina, and we have cared for everyone who came through the doors. Importantly we are located just a few hundred yards from Orleans Parish border, so sometimes the discussion gets a little misleading for people who don't know the geography.

We made the decision to stay open because simply that is our public duty to do it. Since Hurricane Katrina, Ochsner professionals have quietly gone about the business of taking care of thousands of people despite the fact of receiving significant damage to our facilities. We have been diligent in restoring our facilities and moving ahead with the idea we will just keep going until we run out of gas because so many people depend on us.

We also had to provide food and shelter for our staff as well as pay them for their increased long hours during this time. Our extensive disaster preparations played a major role in our ability to mitigate its damages and our ability to provide full services, even under emergency conditions, and this preparedness allowed us to continue to meet the needs of the community. As short-handed as they are, I think it would have been much worse if we had not been prepared.

We have had numerous and extensive financial losses that I think were, for the purpose of brevity, were covered in our submitted testimony.

I would like to tell you about clinical care. It is something that I think is at the heart of the question here. We currently employ over 600 physicians and about 130 mid-levels. That is about 750 people who take care of people directly and importantly receive no direct care for taking care of patients. That is one reason we bear a disproportionate share because we have this large group.

We don't seem to fit the standard stereotype I think what you think of in medicine. We are basically everything. We are a large academic institution. We are a large ambulatory system and we are also a hospital system. Basically our Government is not prepared to deal with organizations like that, the kind of organizations actually you need most during a crisis.

We are one of the largest private, non-university based academic institutions in the country with over 350 residents and fellows. We have about 70 guest residents from Tulane and LSU. We provide advanced research, translational research, and conduct hundreds of clinical trials. In addition, we provide training for over 400 allied health students. These are the folks who make hospitals run—as well as over 700 medical students from both LSU and Tulane with little or no funding to support that mission.

The importance of Ochsner's graduate medical education program has increased greatly since Katrina because we are the only fully functional academic center in New Orleans right now. We currently have done everything we can to support our schools. We want them to come back. They are important for our future as a State. We know that a significant number of physicians locate to

practice where they train, and we are training the next generation with our colleagues.

The sad reality is we are bleeding red ink as a result of holding this fragile health care system and medical education system together. We are caught in the middle of an inflexible bureaucracy. Basically we have State, local, and Federal Governments living off of our balance sheets at the moment; and we can't do it much longer.

Simply put, well-intended money to help us as providers is not reaching us on a timely basis; and when it does, it is insufficient to meet our needs. Basically, we put the company on the line to do the right thing and the bet is still out. Despite our efforts at retention, we had no layoffs; we have laid off no one. We still lost over 2,000 employees and more than 100 physicians after the storm because people just decided they had had enough. As a result, we are experiencing a shortage of highly trained physicians, nurses, and support staff. Recruitment and retention continues to be a major issue for us. We are spending \$20 million annually in employment agency fees to staff critical areas to stay open. We are losing money to stay open and meet the public need. Our wages have increased close to 11 percent. While our health care system costs have increased almost 11 percent, the Medicare wage index decreased almost four percent; and the difference is something we cannot sustain.

To attract talent, we need to cooperate, to operate, and to increase our profitability as wages increase as well; and we have been unable to do that. A permanent fix, as Gary mentioned, to the Medicare wage index would be most helpful in addressing this issue of sustainability.

In 2006 the Ochsner Clinic was forced to increase physician salaries by \$6 million or 5 percent, and we anticipate a similar increase this spring.

In addition, we are often forced to pay significant recruitment bonuses to attract staff at all levels. We are committed to remaining full capability until the end.

Ochsner Health Systems also faces a \$4.4 million in outstanding unemployment claims despite the fact that we had no layoffs. This is an issue between the State and us and the Federal Government, and in my submitted testimony, we have a suggestion in mind.

Funding for uncompensated care is also an issue for us. Ochsner has done more than its fair share for caring for the uninsured in the region. We have seen over 40,000 patients in our system, and our inpatient costs alone cost over \$25.5 million. We have been reimbursed about \$12 million for that. Please note that I am referring to costs and not charges, and these refer to hospital services only and does not address our clinic load.

With over 1 million clinic visit a year and over half of our revenue coming from physician services, our approach is simply not understood by government at all levels. We are more than a hospital system, we are a medical system. Our uninsured and Medicaid volumes have increased 50 percent from pre-Katrina levels. The time between providing the care and receiving reimbursement has become excessive. We recommend that money for reimbursement for the care of the uninsured follow the patient directly and not go

through multiple parties in order to expedite these funds receiving providers of all kinds on a timely basis. Predictable funding is absolutely essential to predicable access for patients as you heard from the previous panel. And access is at the core of good medical care.

I would like to talk about our efforts to expand capability and the retention of health professionals.

Mr. STUPAK. Could I ask you to summarize a little bit there? We are way over.

Dr. QUINLAN. Yes.

Mr. STUPAK. Thanks.

Dr. QUINLAN. OK. Basically we have a lot to do. We have acquired new hospitals, some of which were in the news for failing and we will need some help in restoring those to make sure for the next crisis that they will be there. And also for the professionals who depend upon them for the livelihood. They will have a place to work and a place to stay.

I would like to say just in closing, I think the promise of ongoing supervision and collaboration with this committee will make all the difference between what we had before and what we will get in the future. Thank you for your efforts.

[The prepared statement of Dr. Quinlan appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Doctor. Mr. Smithburg, please, for 5 minutes.

STATEMENT OF DONALD R. SMITHBURG, EXECUTIVE VICE PRESIDENT/CEO, LOUISIANA STATE UNIVERSITY, HEALTH CARE SERVICES DIVISION

Mr. SMITHBURG. Chairman Stupak, Ranking Member Whitfield, members of the subcommittee, I am Don Smithburg, CEO of the LSU Health Care Services division which comprises most of the State public hospitals and clinics that serve as the public teaching system in Louisiana. I also represent the facilities that Dr. Fontenot showed you in her brief video during the first panel. Many members of this subcommittee, as well as a delegation led by Representative Clyburn, took time out to travel to New Orleans several times to survey the devastation. I have had the privilege personally spending quality time with each of you and your staff in the field and very much appreciate that and your commitment to our region and its people.

Ms. Blackburn asked of the previous panel a few question about bricks and mortar, so let me tell you very briefly our story in that regard. Immediately after Katrina destroyed our buildings, we established limited clinic and urgent care services in 10 hospitals, then in the Convention Center. We operated a major clinic in a vacated department store right next door to the Superdome, and in November 2006, just a few months ago, we reopened part of our University Hospital. FEMA indeed funded this renovation, provided the facility would be operated only on a temporary basis. This small interim hospital now operates 20 clinics which is in stark contrast to the 160 clinics that existed on the campus before Katrina. LSU plans to open seven neighborhood clinics in the area as soon as permits are finally granted by the city.

With the destruction of Charity Hospital, our flagship, the region lost its only level one trauma center as noted by Representative DeGette and other members. LSU then leased space at a suburban Ochsner facility and began providing trauma services there in April 2006. Trauma moved back to the interim hospital just last month.

Also, LSU has indeed entered into formal collaboration with the VA to build and operate a joint facility to permanently replace public and VA hospitals. While this innovative project will not be realized for a few years, the partnership and the promise of a state-of-the-art academic health center does help us resolve some of our short-term challenges, such as attracting and retaining LSU and Tulane faculty and researchers, not to mention the thousands of jobs and significant value to the region's economy. And let me be clear. LSU sees this project, this VA collaborative, as a meaningful step toward health reform, not the same old Charity model. We more than everyone want to get away from the so-called two-tiered financing of health care.

And pre-Katrina, 70 percent of the practicing doctors in Louisiana completed all or part of their training at Charity and University Hospitals. But our educational programs are in grave jeopardy as noted by Mr. Whitfield. We lost our radiology and surgery program and most of our orthopedic surgeons. We no longer have trainees in oncology or rheumatology. Other key programs are still relocated far out of town. Surgeons are under increased strain because of the manpower shortages and enormous trauma demands.

Just a word about reimbursement. Public hospitals rely heavily on the Medicaid DSH program in Louisiana and across this Nation. Unfortunately, CMS considers costs associated with payment of non-faculty positions to be unallowable under DSH. They are not regarded as hospital costs. We have been working to address this rule since 1999, and now would be an ideal time to address it.

Another Medicaid financing issue is CMS's proposed Medicaid regulation that will cut billions from the program. We simply are in no position to absorb these additional cost cuts.

Mental health. There has been a significant loss of capacity in the mental health system as a result of Katrina. Only about 40 of the 400 lost psych beds have been restored in the area so far. There has indeed been an exponential increase in mental illness. ER's are under strain because of the volume of the patients whose conditions require special facilities and expertise not currently available. ER's weren't designed to accommodate the needs of these patients and certainly not in the volume we see today. According to press reports, police often are unable to find a hospital able and willing to accept mentally ill citizens. They are booking many of them in jail.

Emergency room overcrowding existed prior to Katrina but has been significantly exacerbated since then. Several panelists have already noted that. One way to alleviate the situation is implementation of the medical home clinic concept promoted by the State and its health care Collaborative referenced by the chairman in his comments as well as other panelists before me. This medical home will be the Holy Grail of recovery and reform for it will address issues such as electronic record interoperability that Dr. Verges noted in his remarks.

And then lastly, workforce. There has been a mass exodus of physicians and other medical personnel from New Orleans. They are in huge and gravely short supply. As you know, members, our challenges are great. We must overcome political in-fighting and self-interest so that the interests of the patients are not lost. Our task is to finally level the playing field of the entire health care community to arrive at solutions that transcend parochialism on behalf of the patient. As noted in my written testimony, we cannot accomplish our mission without additional Federal assistance in the form of increased funding and regulatory changes, not just for recovery but for reform.

It is my hope that the attention this subcommittee can help facilitate a productive dialog and produce positive changes for the citizens of our region.

Thank you so much.

[The prepared statement of Mr. Smithburg appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Mr. Smithburg. Mr. Hirsch, please, for 5 minutes.

STATEMENT OF LESLIE D. HIRSCH, PRESIDENT/CEO, TOURO INFIRMARY

Mr. HIRSCH. Thank you, sir. Chairman Stupak, Ranking Member Whitfield, and members of the subcommittee, thank you for inviting me to testify today and for continuing to keep New Orleans and post-Katrina health care a national priority.

I am here today to speak about a number of issues that continue to plague Touro and other hospitals in New Orleans. I am the president and CEO of Touro Infirmary. Thank you for your support of New Orleans in the 18 months since Katrina devastated our city. We are grateful for your continued interest.

The delivery of health care in New Orleans today is a much greater challenge than it was in the first few months following the storm. Conditions have worsened and continue to do so as more individuals return to New Orleans and as the demands on the health care system increase. Health care is a core requirement of the city's recovery, and the current system is in jeopardy. Additional Federal support is desperately needed to help stabilize and improve the situation.

Touro Infirmary was founded 154 years ago and is a faith-based community, not-for-profit organization. It wasn't until Hurricane Katrina struck that Touro would confront its greatest challenge ever. For only the second time in its history, Touro Infirmary closed on September 1, 2005, as we were forced to evacuate 238 patients as well as hundreds of staff and family members. We are very proud to be the first hospital to reopen in the city just 27 days later and to be a critical part of New Orleans' recovery, along with our colleague institutions that have also shouldered a great burden.

Touro's reopening was critical to the city being repopulated, and since then we have played a safety-net provider role; and this has occurred at a huge financial cost. Katrina caused over \$60 million in property damage and business interruption losses. We have had substantial operating deficits since the storm, and the Touro Gov-

erning Board recently approved the deficit budget for 2007. We continue to erode our cash reserves at a rapid pace and endure the impact of resulting changes in our bond and credit ratings.

The situation as you have heard today in Orleans Parish is particularly challenging as the number of acute beds in operation remains dangerously low at about 500 to serve a population estimated at 200,000.

With 2,000 employees, Touro is presently staffed for 280 beds. There are a significant number of issues that have had a negative impact on the operation of hospitals in the New Orleans metro area and the health care delivery system. The amount of uncompensated care provided by area hospitals and in the increased percentage of population that is uninsured is unprecedented and exceeds national levels. There is also a significant portion of the population that is underinsured.

Touro's charges for uncompensated care have skyrocketed from \$17 million pre-Katrina to \$41 million in 2006, an increase of 141 percent. Our emergency department has seen a dramatic increase in volume post-Katrina from approximately 20,000 visits a year to 30,000. Uninsured patients originating in Touro's emergency department are responsible for about 90 percent of Touro's uncompensated care. This is an unsustainable position for Touro and is an unfunded mandate that we willingly accept but must be addressed in terms of the financial viability of our hospital.

There has been a steep rise in the cost of labor, excessive reliance on contract labor, and shortages of critical health care personnel to fill both direct care and support positions. The national nursing shortages exacerbated in post-Katrina New Orleans, and salary rates have risen significantly. The use of contract or agency labor particularly with respect to registered nurses is a large component of the labor shortage issue. At Touro, the cost for each man-hour paid increased 20.4 percent from 2005 to 2006 driven largely by the cost of temporary labor which increased nearly 500 percent. Annually, the cost of a full-time equivalent registered nurse provided via a staffing agency is \$50,000 higher than the cost for a similar nurse with salary and benefits employed by the hospital. 17 percent of our labor costs last year was for contract labor and amounted to nearly \$14 million.

Graduate medical education. Post-Katrina Touro and other hospitals expanded their residency training programs to absorb as many residents as possible, thereby supporting and protecting the future of graduate medical education in New Orleans. We increased from 18 to 52, however because of this it has been very costly in that the Federal rule does not permit Federal full reimbursement in the first year. Instead, costs must be averaged over a 3-year period; and in effect, we are being penalized. This rule did not envision the hardship created by Katrina. Our incremental costs associated with this for the 3 years of the averaging will be \$9 million, and of this amount, \$4.5 million is related to the 3-year averaging requirement.

Property and casualty has also skyrocketed. We are up 374 percent. At the same time, our coverage has declined. We have taken a number of steps to help ourselves, but yet some of these meas-

ures have not been seen fit to be funded by FEMA which I could elaborate on in greater detail.

Our recommendations are simply to implement health care redesign that provides participants with freedom of choice to obtain health care services and assures that funding follows the patient and is not institution specific. Approve cost-based reimbursement for the next 3 years for hospitals in hurricane-affected parishes, and particularly, for hospitals located in the hardest-hit area, region 1. Treat our hospitals as critical access hospitals similar to what has been done for rural institutions or those institutions in rural areas.

As noted before, approve a Medicare wage index now that reflects the current conditions and don't wait 3 years for the rates to catch up. Increase funding for uncompensated care and consider special grants for those hospitals most affected. Approve waivers for graduate medical education so the problem that I described before will not affect those institutions that stepped up, and also approve additional family practice residency training slots to increase the supply of primary care physicians and waive the administrative barriers that are in front of adding those programs.

Increase access to physical rehabilitation services. Physical rehab service particularly for brain injury patients are in short supply; and at no cost to Medicare, rehab hospitals could be permitted to change status to become rehabilitation units of general hospitals without the current 1-year reduced payment penalty. Approve additional funding to increase health manpower and revise existing programs to incentivize physicians and others, nurses, et cetera, to come to New Orleans for perhaps a 3-year period with grant support. Designate us an underserved area for this purpose, and provide hospitals with direct funding to provide similar incentives.

Deploy Federal resources to help relieve pressure on emergency rooms in the area. DMAT teams were very useful after the storm but left well before the population returned. DMAT's should be reconsidered and redeployed to help alleviate the excessive delays in treatment and overcrowding that currently exists in hospital emergency rooms. Finally, please consider additional funding to offset the cost increases in property and casualty insurance that I noted before.

I thank you again for the opportunity to be here.

[The prepared statement of Mr. Hirsch appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you and thank you to all the witnesses for being here. We will start with the questioning, 10 minutes for each.

You know, you all put in countless hours and energy and your talent to try to solve the health care problems that New Orleans faces, especially in region 1. And yet the health care system, as we have seen today, seems to be deteriorating and not getting much better.

I asked the other panel, but let me ask this a little differently because of the makeup of this panel. Give me one thing that is breaking down in the Government and the private or public sector's ability to solve some of your challenges. Mr. Hirsch concluded with his. I talked with him about DMAT. I don't know if that is something we should do right now or anything we could do right now

to help alleviate the problems; but Dr. Miller, let us start with you and we will go right down the line and give Mr. Hirsch a chance to think about that one. What could we do? Give me one thing we could do right now that you need the Government to put some pressure on—besides the dollar part. We understand dollars.

Dr. MILLER. Certainly one of the greatest challenges for us as a training institution which will affect the current and future supply of physicians is the difficulties related to our graduated medical education programs, being able to move residents from the hospital where they trained prior to that hospital going down to new locations; and as Mr. Hirsch pointed out, those new locations getting adequately paid for those residents so that they can reimburse the medical schools. And we are all under very careful scrutiny by our accrediting agencies, and we have to make sure that the quality of the educational experience and the interaction between medicine, surgery, pathology, all of those trainings are intact.

So certainly we need flexibility within CMS and we need a clear understanding of what the criteria are for acceptable training sites.

Mr. STUPAK. Mr. Muller?

Mr. MULLER. Access to nurses. We simply could open more beds if we had more nurses. Every hospital in town could open more beds if they had more nurses.

Mr. STUPAK. You have the physical space?

Mr. MULLER. Oh, absolutely. We have the physical space. We have the support staff basically. But the nurses are not there. We cannot go on paying agency nurses because they cost like we have been told twice as much.

Mr. STUPAK. What is the barrier? Just no nurses in the area? Is that just it?

Mr. MULLER. Yes. Well, there are many barriers but the main one, there are no nurses in the area.

Mr. STUPAK. And that is housing or—

Mr. MULLER. People really don't want to move back for various reasons, schools, levees, housing, other things. In fact, when you compare living and working in New Orleans to living and working in Austin, TX, Ann Arbor, MI, there is no choice for quality of life at this point. It is really nice to come to a city where the streets are clean and things are going on like it is in Washington. You cannot attract nurses to come back to an environment like this.

Now, another answer, though, is we received volunteer Veterans Administration nurses at West Jefferson for about 6 months. They were wonderful. They enjoyed doing it, they had jobs. I think something needs to be done I believe at that level that will cost less. We cannot hire agency nurses forever.

Mr. STUPAK. OK. Mr. Quinlan?

Dr. QUINLAN. It lapses a little bit into the financial piece, but I think if we could make reimbursement reflect current costs, I think some of that is by design that makes sense in ordinary circumstances. But if we could review some of these administrative rules to recognize that this is an unprecedented situation and it should reflect current reality, I think it would put us on a different footing because sustainability is how you make your plans going forward, and in the absence of predictable revenue stream, you have to think differently.

Mr. STUPAK. Give me a specific on your reimbursement you are talking about, such as critical access hospitals?

Dr. QUINLAN. Well, that would be huge if we could do that, but I remember about in the first week saying, if we could have a critical access designation, this would be tremendous for us.

Mr. STUPAK. And how long would that have to stay for? There is always a concern that once you do it, it never goes back.

Dr. QUINLAN. Pick a number.

Mr. STUPAK. A year? Two years?

Dr. QUINLAN. We can live with anything to tell you the truth. It is taking I think a year-to-year or a biannual sort of thing where you would judge it against certain criteria. It would allow us to have that sort of wherewithal to deal with this.

Mr. STUPAK. Mr. Smithburg?

Mr. SMITHBURG. First I agree with the comments made by my colleague panelists. I am going to add another one. Everything, Mr. Chairman, seems to touch money in one way or another.

FEMA has already been budgeted, and as I appreciate appropriated and authorized dollars. And so in the case of the public, it is a matter of dislodging funding to fit within the FEMA center lane. And in the case of the mental health crisis, while we have tried to find several facilities to lease, at the end of the day we have finally landed on one that will work so that we can stand up a mental health hospital to support the community, but it requires FEMA's approval and that is an issue that we continue to have trouble getting across.

Mr. STUPAK. FEMA approval for what, for allow more cost or—

Mr. SMITHBURG. No, FEMA approval to replace that which was destroyed by Katrina in the form of mental health beds. And we have a beat on leasing a facility that requires renovation that should be eligible by FEMA. And I think that would help the community greatly.

Mr. STUPAK. OK. Has FEMA resolved your money yet for Old Charity? The last time we had a hearing that was a big point of contention, and they were going to do it right away they told us. So what ever happened there?

Mr. SMITHBURG. It is still being evaluated, Mr. Chairman. They did bring in another team, the fourth different evaluation team is now in to Big Charity to adjudicate that claim if you will. But FEMA has helped us get into University Hospital as a temporary facility.

Mr. STUPAK. What is the dollar difference we are at yet?

Mr. SMITHBURG. I don't know. The last official dollar difference is the same place we were before which was \$225 million. But I think they have a new group in there that is looking at it a little more objectively.

Mr. STUPAK. OK. Mr. Hirsch?

Mr. HIRSCH. A couple of ideas. It was mentioned earlier about the frustrations in New Orleans and Louisiana among the different groups, the State, the Federal Government, as well as of other interested parties. And I don't know to the degree that this is practical or realistic, but to the degree that Congress or someone can play a role in mediating or trying to arbitrate the situation so to speak. There are a lot of people working with a lot of good inten-

tions, in some cases, frankly, at cross-purposes; and people need to get together and have what I would call a real conversation and try to reach a middle ground and compromise. That has been a big part of the problem. I don't think that the parties are all speaking with each other.

Mr. STUPAK. Mr. Dingell has asked the Secretaries of HHS, FEMA, some of the others, to sit down as a group. Would you be supportive of that?

Mr. HIRSCH. Absolutely, as well as all representatives or representative constituencies of the industry, the private—

Mr. STUPAK. Well, that is why our first panel was so big. I know I was harassed a little bit because of the size of the panel. But we didn't feel like we could exclude anybody because you all have a stake in it. We want to get you together and get you talking.

Mr. HIRSCH. And I think that would be wonderful and that is—I think that situation is what is going on there and that is a big roadblock is if the parties aren't speaking.

The other thing, some of the comments that were made earlier about the requirements of DSH, some of those requirements preclude for instance, say, Don's organization and us at Touro, we at Touro, from potentially contracting for services and not having to have patients go 60 miles, not having backlogs as well. So that is something that I think is real. It ought to be considered.

And finally, one of the recommendations that I noted in terms of access to physical rehabilitation services. We think that is an easy lift. We are a hospital within a hospital now, and if we could convert without a 1-year penalty, we believe we could get certain economies and increase access. So that is something that we are working on.

Mr. STUPAK. Let me ask this question. We have talked a lot about dollars following the patient, and that has been throughout both sides of this dais today talking about it. However, the fear that sort of comes out is as the dollars follow the patient, the private hospitals if you will, will only take the healthiest patient and the less healthy, those with HIV's, the prisoner patient, would be left then to the public. And as we try to work this out, it is not just this committee, but 435 of us in the House of Representatives alone, it is a hard built-in bias, whatever you want to call it, to break. People are afraid that if we do that, some people will skim off the healthiest patients and leave the poorest. Care to comment on that, Mr. Muller?

Mr. MULLER. We are taking them right now and would be glad to.

Mr. STUPAK. That is what we are hearing from your lost revenue and things like that.

Mr. MULLER. That is correct. We are a public hospital. Our mission is to take care of people. We have patients lined up every day to come to West Jefferson. We have a continuum of care. If the money followed the patient, it is a win-win. It is not a problem with us.

Mr. STUPAK. And your comment, Mr. Quinlan?

Dr. QUINLAN. Yes, I would just reiterate the same thing. We are already doing this, and I think what we really need to do is allow people to vote with their feet and I think it is very important that

they do that. It helps us all keep better—there is a degree of competition that is healthy, and I would say that is true in any walk of life, including medicine, and trust the common sense of patients to take care of themselves best.

I would like to add one thing. Taking care of this primary care network is probably the most important thing you can do to take care of hospitals because let people do what each does best and no more than that.

Mr. STUPAK. Mr. Smithburg, you want to comment on that?

Mr. SMITHBURG. Well, there is no doubt that the not-for-profit, faith-based and private institutions are carrying their heavy loads since the storm. There is no doubt about that. And after the storm, we lost all of our employees, and our budget was cut by about \$200 million. A good amount of that was actually redeployed to help support my colleague—institutions and caring for those patients that would have otherwise been cared for in our institution. You see, New Orleans has a tradition whereby between 90 and 95 percent of the uninsured got their care at the Charity Hospital, and the balance of the uninsured, the remaining five to 10 percent, was spread around all of the other community facilities. Katrina turned that upside down. And I don't know that she leveled the playing field but she certainly changed the playbook.

And so to the extent that rules, regulations can be addressed to allow for what heretofore were non-allowable costs to be allowable, at least for an interim period of time, I think that helps the entire environment.

Mr. STUPAK. Thank you. Thank you again to the entire panel. Mr. Whitfield, for 10 minutes, please?

Mr. WHITFIELD. Thank you, Mr. Chairman. Thank you all for taking time to come and be with us today. As I was listening to your testimony, I know Dr. Quinlan, you made the comment that we can't do this much longer and we are committed until the end. I think, Mr. Hirsch, you talked about operating deficit and eroding cash reserves; and I am assuming that all of you representing the institutions you represent are in that same boat. Am I accurate in that? I mean, are the eroding cash reserves in a deficit situation and your emergency rooms are being overrun; and that is why I know in the first panel so much emphasis was being placed on this primary care or getting that going which would be of some assistance to you. But Dr. Quinlan, if things continue to go the way they are going now, how much longer can you operate?

Dr. QUINLAN. That is a good question. What we have done is, unlike trying to make a statement, we realize that we are just not going to put the patients in the middle. We are approaching the point where we will have to restrict our policies because if we go under, we can't help anybody. And due to the size of our organization, the impact of that failure would be huge and the impact would be felt by our colleague institutions throughout.

The difficulty is that it is all related. I think the key to us would be that as we cut back, what we would have to do is probably not keep up with wages and benefits; and this vicious cycle we are in in losing personnel would be accelerated. And when that starts to happen, that is what we are afraid of. You know, cycles, you are

either getting better or you are getting worse. And I feel we are sort of hovering right now.

Mr. WHITFIELD. Yes. And do all of you face significant unemployment claims that you are liable for?

Mr. HIRSCH. Yes.

Mr. WHITFIELD. OK. And you, Dr. Miller?

Dr. MILLER. I am just not aware because a University is in a different situation than a hospital.

Dr. QUINLAN. Well, to your point, as I understand it, there was significant relief from Congress for unemployment relief, but it did not apply to not-for-profits.

Mr. WHITFIELD. Oh, it did not apply?

Dr. QUINLAN. It did not apply for not-for-profits. And in our case it is particularly irritating because the unemployment claim we feel was unfounded in the first place. So we didn't get the relief but we got the bill. That is a tough one to take.

Mr. WHITFIELD. Right. Chairman Stupak and I were talking during your testimony about the critical access hospital designation which means you are reimbursed at cost plus. That would be a tremendous help to all of you making it happen immediately, correct?

Dr. MILLER. Yes, sir.

Mr. WHITFIELD. That would really be a significant help, wouldn't it?

Dr. MILLER. I just think one thing—and certainly not to minimize the issues of the hospitals because that is very critical. We can't forget the physicians in the equation.

To every extent, we all represent physicians as part of our organizations, but as little as it has been, there has been some relief for the hospital but there has really been no relief for the physicians. So a patient is admitted through the emergency room and there is a potential for the hospital to gain some reimbursement for it. But that patient has to be seen by a physician or perhaps several physicians, and they are not getting reimbursed for it. And the threat there is that we lose more physicians. It has been stated earlier today that we are down to about 50 percent of our pre-Katrina physicians in region 1. It is significantly more severe than that in Orleans Parish; and I am sure as you know in St. Bernard, it is even more so. And unless we fix the physician situation while we fix the hospital situation, we will wind up with wonderful hospitals and no doctors to take care of the patients.

Dr. QUINLAN. I would concur with that, but I would add that with our new hospitals that we have acquired that were in trouble, when physicians come in—these are voluntary staff—come in to see patients, we pay them Medicare rates because we are trying to do everything we can to keep them afloat.

If you do work, you need to get paid. I think that is not a bad policy in general for the Government to observe.

Mr. WHITFIELD. Mr. Muller.

Mr. MULLER. Yes. If I could, we feel the same way about physicians. We have actually gained physicians at West Jefferson, most from St. Bernard, some from Orleans Parish because we ended up being dry.

But we have done a couple things, one is to share what we could back to the physicians in terms of what we could legally to keep

their offices open, like Dr. Bertucci is trying to do. Second, we are paying them for uncompensated care now in the emergency room; but that is coming out of the hospital's budget which makes our deficit worse. So additional money for physicians is good.

Mr. WHITFIELD. Part of the responsibility of this subcommittee is to come up with proposals, and I know that we have a gentleman from Louisiana on the committee now who is certainly focused on this issue. And I hope that as a result of this hearing we can come forth with four or five proposals like critical access hospital and something related to community health centers and other things to try to expedite something through.

And many of you were talking about the nursing situation, the shortage of nursing; and yet Mr. Koehl I believe talked about that in Louisiana, the State had made a decision that they would not allow nurses to come in from outside this State unless they were licensed. Help me with this. Is that right or did you hear his comment or did you know anything about that.

Dr. QUINLAN. I heard his comment. I am not familiar with the issue.

Mr. WHITFIELD. Well, maybe the next panel could address that because it does seem a little bit odd that with such a shortage that the State would, at least from the testimony from that witness, be an obstacle to bringing more nurses in.

And then another thing that concerns me I think in someone's testimony and I forgot who, it mentioned in the testimony that on 9/11, 2001, that the Federal Government stepped in immediately and provided some immediate assistance to hospitals in the New York area as well as the Washington, DC area. And would anyone want to elaborate about that? Mr. Muller.

Mr. MULLER. I would be glad to. We received a DMAT 12 days after the storm. The DMAT went from positioned in Tennessee, State of Mississippi, didn't do anything, went back to Baton Rouge, didn't do anything, and we got it and we were the first DMAT. Now, there is more that the Government could have done. I don't want to go back, but some of the things going forward could be more grants for health care personnel.

Dr. QUINLAN. I think perhaps you are alluding to the HRSA grants that after 9/11 hospitals closed—largely took people out in anticipation of a wave of casualties that didn't occur. That sort of thing would be great for us and would also be important for the future where—how else can the Federal Government get funds to hospitals? They need to keep them afloat virtually.

That is the kind of thing that would help because I have run into so many people who would like to help but were unable to for a host of reasons that you know all too well, and the HRSA grant possibility is giving the kind of flexibility to assess what the need is and meet it in a timely fashion.

Mr. WHITFIELD. Yes, because I mean, the key thing now is being able to be flexible.

Dr. QUINLAN. That is right.

Mr. WHITFIELD. And one of the frustrating things is health care is so complex that it seems like every time you try to do anything, your hands are tied or it is this regulation or that regulation. It is micromanaged so it is very frustrating. And then our staff had

looked up on the DRA money for example, and I am not being critical of the State of Louisiana because with the catastrophe the size of the catastrophe, but it is my understanding DRA money that the State of Louisiana has is \$140 million left still unspent, SSBG money \$142 million left unspent, DSH money currently \$250 million unspent. I won't even get into the uncompensated care poor or the CDBG monies.

So hopefully this hearing will focus on some of these things, and we can come forth with some sort of legislative proposal to help move it along. But thank you all very much for being here. Listening to everyone you can see why the depression rate is up in Louisiana because it is so frustrating. Thank you very much.

Mr. STUPAK. Ms. DeGette for 10 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. I want to follow up on some of the questions that the chairman was asking. We have been talking about this notion of having some of the State's DSH money reprogrammed to follow the patients, and I have got to say for the gentlemen who are here from the private hospitals, and I say this a lot but I will say publicly again, thank you, because your hospitals treated so many of these patients and are continuing to do so now with minimal reimbursements. And it really has been an extraordinary community effort.

Dr. Quinlan, I have been in your hospital and seen some of the work that you are doing. I am wondering if the three of you gentlemen, Dr. Miller, Mr. Muller, and Dr. Quinlan, can tell me about what would need to be done to reprogram the State's DSH monies to follow these patients and what rules would we need to change at the State and Federal levels. Dr. Miller?

Dr. MILLER. Well, again, currently the way that the State DSH dollars are used, they basically are centered around patient care that has been delivered in the safety-net hospital system with a small amount going to other hospitals that provide significant amounts.

Ms. DEGETTE. Believe you me, I know how DSH works. What I am asking you is what Federal rules and State rules would need to be changed to reprogram these dollars?

Dr. MILLER. Again, I am going to let the hospital CEOs talk for the hospitals, and I will talk for the physicians because again, we have a group of 200 physicians at Tulane University. And the rules need to be changed to allow DSH payments go directly to health care providers other than facilities, and that may be physicians, nurse practitioners, and other health care providers.

Ms. DEGETTE. How long a period would you think that that reprogramming would need to occur?

Dr. MILLER. Well, it certainly needs to occur until we have a stable health care system back up in the region and decisions are made about what we are going to have in terms of a safety-net hospital, how big it is going to be, and when it is going to be available. And so that during the period of time when we are between where we are now and where we are going, there needs to be some type of alternative system.

Ms. DEGETTE. Two to 3 years is what they have been saying to me.

Dr. MILLER. And again, that will depend on how quickly we can get the system stabilized.

Ms. DEGETTE. Mr. Muller, would you have anything to add?

Mr. MULLER. Absolutely. There is a lot of money. The DSH money in Louisiana is large. The reason we are saying let it follow the patient is because it is there now.

Ms. DEGETTE. You know, again, I understand. What specific regulations would we need to change?

Mr. MULLER. My testimony had actually two things, one is the Medicaid proposed rule that would allow the funds that were certified by—now, the certification is done by the public hospitals. And so the certified funds are matched with Federal funds that come in. We are asking the Federal rule to come directly to the provider. Don't go to the State. That is already a proposed rule.

The other thing is a certification of the public expenditures, needs to be something that comes back directly to the provider; and then we can deal with the physician. I think if we get a lot of that money, which in our case would be multi-millions, we would share more of the physicians.

Ms. DEGETTE. And I will ask you the same question I asked Dr. Miller. For what period of time do you think that funding arrangement should occur, that the DSH money should go directly to the hospitals and then onto the providers?

Mr. MULLER. I support having a major teaching hospital in New Orleans. It will take 6 to eight 8 to have that come up. You got others that will tell you other dates but—

Ms. DEGETTE. So you are saying the same thing he does as long—for the period until that public safety-net hospital gets built, you think that that should happen?

Mr. MULLER. Until we have a fully functioning safety-net system outside of my hospital and Dr. Quinlan's and others, we should have those funds come directly to our hospitals.

Ms. DEGETTE. And for that period of time, would your hospital commit to serving all of the safety-net patients including the ones Mr. Stupak was talking about like the severely mentally ill and people with a plethora of conditions and so on?

Mr. MULLER. West Jefferson has a continuum of care. We are doing it today, we will do it until we run out of money.

Ms. DEGETTE. Dr. Quinlan?

Dr. QUINLAN. With regard to the proposed changes, what I would like to do is give you a written response so it could be most helpful.

Ms. DEGETTE. That would be excellent. Thank you.

Dr. QUINLAN. Yes. The second piece on the timing, it should be an event-based decision, not a calendar-based decision. Decide what things need to be dealt with and then if there are certain benchmarks or milestones that need to be reached—

Ms. DEGETTE. But what event would you base the decision on?

Dr. QUINLAN. I think the health care we designed—I have been involved with this committee since its inception, and that I think that is an important piece to determine what is the best way to do this in an ongoing fashion, rather than trying to look backward, how do we look forward and meet the needs of patients. And that is—

Ms. DEGETTE. What event is that, I am sorry?

Dr. QUINLAN. Excuse me?

Ms. DEGETTE. What event would you base—you said it needs to be an even-based decision.

Dr. QUINLAN. OK. Well, the event for example would be do we have a written plan that is acceptable for all the major stakeholders how we are going to deal with health care in the next year or two.

Ms. DEGETTE. Would that include LSU?

Dr. QUINLAN. Of course.

Ms. DEGETTE. OK. And do you support the concept of the rebuilding of a major safety-net hospital?

Dr. QUINLAN. Yes, I do.

Ms. DEGETTE. Mr. Smithburg, I want to ask you, from your perspective, do you think a temporary reprogramming of DSH monies can be developed in a way that won't prevent LSU from building a public hospital in downtown New Orleans?

Mr. SMITHBURG. You know, you used the term, let the dollar follow the patient.

Ms. DEGETTE. It was actually Dr. Quinlan's term that I adopted.

Mr. SMITHBURG. Indeed. Thank you for the clarification. It is a much bandied-about term in Louisiana and I know in other States as well. I think what has evolved is that through the Collaborative that some of us served on, the Governor's Collaborative on Health Care Redesign, it tried to actually define what that is because one of the fears, of course, is that what happens to the patient when the dollar isn't following them?

Do they fall back on a safety-net system that has historically in the New Orleans region also been one of the primary academic flagship institutions? And so the collaborative that we worked on collaboratively came up with a plan that said, there just isn't enough DSH money for, based on actuarial studies, for there to be enough money to follow all of the uninsured patients in the market. In fact, it would cost another half-a-billion dollars conservatively estimated. And then of course, Secretary Leavitt came through the State and proposed another plan after he and Governor Blanco had commissioned the Collaborative; and it called for an insurance plan that did away with the safety-net hospitals, use those funds to insure about 40 percent of the uninsured. So it was kind of a perfect storm as far as we were concerned in the public teaching hospital arena.

So at the end of the day, clearly, Representative DeGette, something needs to be done to protect the business plans of the community hospitals that are doing an outstanding job. But I fear that if it is a 3-year window or a 5-year window, when we get our permanent LSU VA Tulane hospital up and running in 5 to 7 years, whatever it is, if then we say, OK, they are the safety net, they are going to go back to taking care of 95 percent of the uninsured as was the case pre-Katrina, we are right back to the two-tiered funding system again and we will not have advanced the ball in terms of health care reform and perhaps quality and the like.

So I think it is a dangerous proposition to enter into, without some very tight accountability expectations and with an expectation that we are still working toward a real reform of the system, not your grandmother's Charity Hospital system again.

Ms. DEGETTE. I agree with that and I think these things can be worked out because on the one hand, I think everyone agrees we need to—and Mr. Chairman, maybe this is why we brought everybody here together because I think everybody agrees we need to reimburse the private hospitals who have been treating these patients. On the other hand, I think everybody, including the private hospitals agrees we need to rebuild Charity and not in the same footprint. The very concept of disproportionate share hospital, which is actually an issue Mr. Whitfield and I have worked on extensively together, is a hospital that treats a disproportionate share of uninsured patients. So that wouldn't qualify for, except for maybe lately, some of the private hospitals. So the very concept of these monies would be that it would go to a public safety-net hospital. So whether the way we reimburse the private hospitals is through DSH or some other method and the way we think about Charity going down the road is not through a two-tier system. We have still got to work this thing out, and I would think we should be able to.

So I appreciate all of you working on it, and I neglected to say hello to my old friend Mr. Hirsch who used to work at St. Joseph's Hospital in Denver, Colorado.

Mr. HIRSCH. Thank you.

Ms. DEGETTE. So anyway, I think this can be done, and I think a lot of what is trying to be done by Congress and by the providers and the local governments is trying to figure out a reimbursement method that fits. It is sort of a square peg into a round hole or vice versa, a scenario where you are trying to think of these pots of money and how can you get them. But I don't think anybody, and Dr. Quinlan and the others can correct me if I am wrong, I don't see DSH money as a long-term solution to how we treat these uninsured patients.

Dr. QUINLAN. No, and I think what you are saying is exactly correct. We have to make sure that this is a comprehensive plan, not reactionary or piecemeal because each one of these major factors affects the others. This is a variable equation with no constants. We have got to get something that we can build from and have a plan that is sustainable, and I don't think it is just about DSH money and it is not just about primary care, it is about how do we weave together a health care system that is coherent?

Ms. DEGETTE. And that health care system has to include an up-to-date public safety-net teaching hospital and a clinical system with all of the things we have talked about, electronic records—

Dr. QUINLAN. But the order in which you do that is very important. I don't believe we start out with a hospital and then figure out the primary care network that supports it and all the things that go with that. I think it is how do we decide what our goals are, what caliber of education do we want in that region, what caliber of care do we want for patients. Is it going to be something they can walk to, bus to, or bicycle to, and will they be connected in a way that you can actually manage the health of the population as opposed to individuals on a sporadic basis? And we need to spend the time to do it right up front, rather than rushing to just do something on a very large scale. Now, I do think the short-term needs are immediate and really need to be dealt with; but that is

not a substitute for a planned-for approach to a comprehensive solution.

Ms. DEGETTE. I agree. On the other hand, it has been 18 months, and so we need to start to come up with that plan pretty darned quick.

Mr. HIRSCH. May I just add that I think it is important to remember that some of this also depends on the socioeconomics of an area, specific locations. We have a lot of people in our area that are underinsured as opposed to other parts of the country. And take Touro, for instance. We are right in the heart of the city, so we are an urban center; and people will vote with their feet. And so we have to I think keep in mind that even before the storm as well as after the storm certainly that much worse, all these private hospitals and some more than others have been providing a lot of free care; and I think it is important to think about DSH or some other mechanism well into the future, and I certainly support the rebuilding of an academic medical center. I look at it that way as opposed to just a safety net because the health sciences are so important to our city. But I think for a long time to come, hospitals in urban areas, especially New Orleans, will be affected by the uninsured some more disproportionately than others.

Mr. MELANCON [presiding]. Thank you, Ms. DeGette. I think Dr. Burgess is next up for 10 minutes.

Mr. BURGESS. I thank you and let me just start out with this observation. In October 2005, I did visit New Orleans as a guest of East Jefferson and West Jefferson Hospitals, Ochsner Hospital. They asked me to come down there because they had a plan that they had worked out with their medical staffs to stay open, keep their bondholders happy in New York, and it hinged around shaking some money loose from the Federal Government. And the hospitals were going to function as the intermediary through which that money flowed, not only to keep the hospitals open, keep the nursing staff employed, but also to reimburse the physicians for the patients that they were seeing. At this point, when I talked to doctors down there, they had not had any mailed delivered in 2 months' time, their accounts receivable were a shambles, and they were basically living off of their kids' college funds in order to keep their practices open. I thought it was a very insightful, responsible way to deal with a crisis the likes of which none of us had ever seen before. And it is with some pain that I acknowledge we were never able to deliver what seemed to be a very reasonable request by the hospitals that stayed open through the storm and were still standing after all of the trouble that occurred in the days after the storm.

So let us go back for just a moment to the DSH funds. My understanding is there is about a billion dollars a year in disproportionate share hospital funds for the Louisiana area? Now, the \$250 million that we always talk about, is that the money that was from the last quarter of 2005 that wasn't spent because Charity no longer existed and is there an ongoing stream of DSH funds that are coming through the State for administration of care for insured individuals and underinsured individuals?

Mr. SMITHBURG. Dr. Burgess, I will take a crack at that, but that may be a good question to ask of State officials on the next panel as well.

But of the billion dollars roughly speaking about \$600 million of that goes to the public hospital system, the State public hospital system, or it did before the storm. Right now it is about \$450 million. And then a good chunk of it goes to the State psychiatric facilities and for rural hospitals. The breakdown could be provided by the State officials, however.

Mr. BURGESS. So those dollars are now distributed to other State facilities outside of New Orleans?

Mr. SMITHBURG. In the case of the LSU public hospitals, again we had a pretty significant reduction in our DSH dollars after the storm and then some that we previously had in New Orleans that remain, we redeployed to some of our other hospitals that picked up the slack in Baton Rouge, Lafayette, Home Louisiana, and then outright cut.

Mr. BURGESS. I don't now whether you noticed but it is a recurring theme with me that I am just astounded by the amount of dollars that have been pumped into a problem and again, we don't seem to have helped anyone on the ground. You know, I haven't been in public service that long, but it is enormously frustrating to me. I get criticized at home because we are spending so much money on this, and then at the same time, we have not helped anyone in the process. So I do wonder what happens to \$100 billion in appropriations that we sent down in 2005. I wonder what happens to \$2 billion we sent to the DRA. I wonder what happens to \$2 billion a year that is available in DSH funds. And at some point, I hope someone can give me some type of spreadsheet that will give me some insight into that to at least give me some comfort. Someone, and I don't remember who, talked about some of the barriers for the critical access hospitals, but that seemed to me when that discussion was going on, very similar to the plan that was outlined by East Jefferson, West Jefferson, Ochsner Hospitals in October 2005. So I think it was actually Chairman Stupak who asked the question, what can we do at this level to see that those funds actually go into those critical access hospitals and are there for immediate distribution? Does anyone have an insight into that?

Dr. QUINLAN. You will need to change the definition of eligibility. They are size-limited. I think they can only have 25 inpatients. It depends on how you define critical access. It was defined with a rural environment in mind.

Mr. BURGESS. Well, perhaps we could denote a special category for a special, once-in-a-lifetime catastrophe.

Dr. QUINLAN. I agree with you. It is called flexibility, and that is what has been absent in all this.

Mr. BURGESS. Well, you are right on that.

Mr. MULLER. Dr. Burgess, can I follow up and show you what could be done? West Jefferson is about eight miles from a critical access hospital. St. Charles Parish is right next to Jefferson Parish on the west bank. St. Charles Parish has a critical access hospital. West Jefferson is not, of course.

Mr. BURGESS. Since you volunteered that information, Mr. Muller, let me ask you a question about the nursing. You said that you

are spending a lot more money on agency nurses than what you would spend on nurses who were salaried and on your staff?

Mr. MULLER. About twice as much, yes.

Mr. BURGESS. Where does the agency get their nurses?

Mr. MULLER. All over the world. They get them from California, Michigan, and everywhere else; and they fly in, we pay for them.

Mr. BURGESS. The question that Mr. Whitfield brought up about the licensure issue, is that something that concerns you? Is that going to be a problem with the agency?

Mr. MULLER. We have not had that issue with our agency nurses, no.

Dr. QUINLAN. I believe that was referring to volunteers.

Mr. BURGESS. Just to volunteers? But if you have a nurse from Dublin, Ireland, who is licensed to practice nursing in Ireland—

Dr. QUINLAN. That is a different story altogether. That is a visa question which is something we could receive help on certainly. We are planning on pouring a large number of nurses from out of the country as well to meet this need, about 100, and we have been shepherding this with the help of our delegation actually, shepherding their immigration along. But that is the sort of complexity we are—if we could address that—because we are in the midst of a national shortage that is just exacerbated by our particular situation.

Mr. BURGESS. But even if you are able to steal nurses from Detroit, Michigan, are you going to have the licensure issue that comes up in a month's time?

Mr. MULLER. No, I don't believe so.

Mr. BURGESS. How does the agency get around that?

Mr. MULLER. They work out the requirements with the State Board of Nursing.

Mr. BURGESS. So there is a reciprocity agreement?

Dr. QUINLAN. They are travelers and these are people that do this for a living basically, at least for a period in their lives. So they have licenses at different States as well.

Mr. BURGESS. One of the other issues that came up was that we are not able to reimburse CRNA's and physicians under some CMS rules, that those funds have to go directly to an institution and not to a provider.

Dr. QUINLAN. Right.

Mr. BURGESS. Again, is there some flexibility that we can provide you that we are not that would allow you to pay these providers and keep them in the area?

Mr. SMITHBURG. Hi, Dr. Burgess. I will be one of those to take a crack at that. In fact, when I was your constituent in north Texas, I worked for a hospital system where CRNA costs were indeed considered allowable by the fiscal intermediary which is the same fiscal intermediary that oversees Louisiana as well. So there seems to be some variability in interpretation of those allowable rules in different regions of the country.

So it is one of the reasons why I feel very strongly it is something we need to pursue.

Mr. BURGESS. So that must be a question for the third panel.

Dr. QUINLAN. We will get you a written response as well to see if we can help you with your options.

Mr. BURGESS. Very good. Dr. Quinlan, just in the time I have left, you talked about a coalition for the uninsured, your overall health care redesign and developing a plan for the delivery of that health care. Can you kind of just give us some insight as to where that is in the development process, who is involved, and where it is going?

Dr. QUINLAN. Yes, actually there are a number of players, many of whom—it is a sort of a reconstitution of the previous redesign plan that we just wanted to get back together and pose an alternative to what we see basically—I shouldn't say happening, just not happening—and many of the critical players on the ground including the PATH group that you saw, many of the hospitals including Tulane and East Jefferson and West Jefferson, most of the major players, Dwayne from Charity. We are trying to come together in a way saying—I think the key piece for us is to do a pilot program that involves only region 1. That is the area that took the brunt of the damage. It is something that gets away from what was alluded to as dueling spreadsheets. The smaller the area, the more precise you can be with the information about the number of the uninsured, where they in fact live, where the clinics need, and so forth—logistical questions around how do you actually get the care to people. And that is what we have been focusing on. I think by the end of this month we probably should have something that is a good start on an alternative system, and I would ask everyone's patience. Designing health care systems for coalition of people who have day jobs is a difficult task but I think one that, given our areas of expertise, that we can come up with a framework of a credible alternative.

Mr. BURGESS. Let me just for one final thought if I could, we have been focusing on the inflexibility at the Federal level, primarily through HHS and CMS. Are there any areas where you can help us with the problem of flexibility that you are having more at the local or the State level? Are there areas there where perhaps we need to be focusing some effort, some energy?

Dr. QUINLAN. There is a recent, relatively small development but is another bottleneck. What we are all trying to do is find bottlenecks and resolve them. As I understand it, our own State Licensing Board for physicians has outsourced that function, and we have noticed there has been a significant delay now in getting the people we finally were successful in recruiting into the State, getting them licensed. Our most recent was a neurosurgeon who is on the payroll but can't get his license. And he trained at LSU, incidentally, and he came from Texas.

Mr. BURGESS. Now wait a minute. We need him back.

Dr. QUINLAN. I know. I will swap you in two draft choices, maybe.

Mr. BURGESS. Mr. Smithburg, you alluded to something about a cap that is on the reimbursement for public hospitals under some of the reimbursement. But that is largely a State-imposed cap, is that not correct?

Mr. SMITHBURG. Dr. Burgess, that is correct. There is a State-imposed cap on Medicaid. There is a public program and a private program, if you will, or all other—

Mr. BURGESS. I know my time has expired, but if we work on flexibility from our end, will you help us work on flexibility at the State level as well?

Mr. SMITHBURG. You can count on it. Yes, sir.

Mr. BURGESS. Thank you.

Mr. MELANCON. Thank you, Dr. Burgess. I recognize Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman. I thank you all for your patience and your endurance today.

I am going to start out with a homework question for each of you, and please understand, going back to the first hearing that we did in New Orleans following Katrina where we were told if we can just get some money, if you will just get us some money down here, we can take care of this. And now we are hearing from you we can't find the money, we don't know where the money is. I feel like we are playing a game of Where is Waldo at some point. So pencils and papers, here we go for the homework, and then if you will submit this to us we want to be certain that you all have access to the funds you need, that you are able to do the work that you need to do. But I think we also have to—we are not having a hearing on the implosion of the Mississippi health care system, we are having one on the implosion of the Louisiana and New Orleans, and so help us work through this with finding where the money is.

The DRA money, you all were appropriated \$2 billion to Katrina-affected areas. Louisiana got \$918.2 million of that. They have spent \$778.7 million. There is \$140 million left unspent. How much have you applied for, how much have you received, and how much are you waiting to hear from?

SSBG money. You got \$220.9 million. \$78 million has been spent, \$142 million is left. Same question, what did you apply for, what did you receive, how much have you not heard about?

DSH, money. You are getting about a billion a year, \$250 million has been unspent, and then what are your outstanding balances with DSH.

Workforce recruitment money. And Dr. Quinlan, I know you are probably using this on some of those nurses that you are bringing from—

Dr. QUINLAN. We are not. I21Mrs. BLACKBURN. OK. I thought with all of these nurses that you were bringing from around the world from places like Michigan, down south you might need an interpreter for them, right?

Dr. QUINLAN. Right.

Mrs. BLACKBURN. OK. Workforce recruitment money, Louisiana has gotten \$15 million. They have been sent \$15 million. And then the uncompensated care pool, \$120 million has gone to Louisiana.

So kind of help us as a committee get our hands around, out of that money what have you applied for, what have you received, what have you not heard from, so we have a better idea of what is outstanding. Now, the CDBG money, I know Louisiana—LSU has a \$300 million request in on that I do believe, and those are specific to you all with LSU.

So anyway, those first five areas, answer those. Mr. Smithburg, let me come to you quickly. I want to get these in before we go to

vote, so I am going to speed it up, Mr. Chairman, and see if we can get through this.

LSU is looking at seven neighborhood clinics in New Orleans as soon as you get through the zoning and the red tape. Can you not get somebody with the city of New Orleans to help speed that process along for you all? What is the barrier there? Can you articulate that for me?

Mr. SMITHBURG. I wish I could, and the next panel may have a panelist that might be in a better position to answer that. It has been an arduous process. We are riding a game plan along with way with many of these issues, but I am hoping that we are within 100 days of being able to deploy these mobile clinics that have actually been sitting in our parking lot for some 8 months.

Mrs. BLACKBURN. Seven or 8 months the clinics have been sitting there and all the other hospitals, out of the goodness of their heart, are soaking up this care and the city of New Orleans is not approving these clinics, am I stating that properly?

Mr. SMITHBURG. Yes, ma'am.

Mrs. BLACKBURN. All right. Do we know if the problem is primarily with the State or with the city?

Mr. SMITHBURG. Oh, I know it is not with the State, and I believe it is at a point now where an ordinance has been passed to grant a temporary zoning variance. So we may be a few months off now.

Mrs. BLACKBURN. OK. On page 4 of your testimony, you talked about the VA and moving forward on that. This is an issue that has been highlighted time and again with us, so speak for the record briefly about how you all are meeting the needs of the existing VA population.

Mr. SMITHBURG. Well, again, I think on the next panel you will have a representative from the Gulf Coast on that.

Mrs. BLACKBURN. OK. Do you care to make any further comment?

Mr. SMITHBURG. I would note, and thank you for the question, that the VA LSU Tulane collaborative is really one of the most exciting, innovative propositions to come before our market or really any in a long, long time; and should we be able to receive the CDBG infrastructure funding to get that launched, I think that is going to be good for preserving, protecting, and growing medical education as well as of course re-engaging more beds for the community.

Mrs. BLACKBURN. OK. I want to go to your comments about the DSH payments on page 6 and you talked about the methodology. And reading this, my thought was when you look at Louisiana's health care system, are you saying that it had some specific strains and stresses and some amount of brokenness pre-Katrina and then this has exacerbated the problem? And I would like to hear how you would respond to that, and then I concur with Congressman Burgess in looking at what we do to address the financing situation that you all are dealing with. You know, the state of the system pre-Katrina and then if there was an exacerbation of that situation, what degree you would place with that?

Mr. SMITHBURG. Clearly before the storm, there were broken parts of the health care delivery system across the entire delivery

spectrum; and it boiled down to, of course, money, in my view anyway, that there were not enough resources to cover the needs of the uninsured, the underinsured.

We are a small business State. Ninety-five percent of our businesses have 50 or fewer workers. So almost by definition there is going to be a huge uninsured population. And while there is a structure I believe in place, a knitted together fabric of safety-net facilities, it is desperately under funded and since Katrina and the fact that those antiquated facilities were wiped out, my brethren here at the table have had to pick up the slack. And so it is exacerbated indeed.

Mrs. BLACKBURN. Well, we find it amazing that you are not able to get approval in the city of New Orleans when your brethren at the table have been picking up that slack. And to find that just having been down there in the city holding these hearings and then to see that there still has not been a real solution to that issue, it is a touch of a head-scratcher, if you will, especially with the mobile clinics being sitting in New Orleans. I mean, it makes you wonder, is there a still permitting problem? Are we still trying to figure out who is going to have a hospital that is permitted? So, we are concerned about that.

I have two more questions that I wanted to get to. I am going to submit these to you. One deals with your outpatient facilities and your long-term care beds, the other is going to deal with the mental health component that you have mentioned. We will submit those to you, and I am going to yield my time back so you can get your questions in before we vote.

Mr. MELANCON. I thank the gentle lady from Tennessee. Let me start by asking I guess everybody that is sitting at the table. Has anybody from the Department of Health and Human Services come and said to you, "I am here to help you. Tell me what it is that you need for us to do so that we can help you get back up and running?" At all? Anywhere?

Mr. MULLER. I can start. Six days after the storm, actually Secretary Leavitt, Dr. McClellan, Dr. Gerberding flew into New Orleans, met with I believe Dr. Quinlan and myself and a representative of East Jefferson; and that was the start. I think since then, we have had large meetings. I really haven't gotten into the details of those, Congressman, but no one has come to West Jefferson if that is your question.

Mr. MELANCON. OK. Anyone else?

Mr. SMITHBURG. Yes, Mr. Chairman. I would like to note on the upside, actually, right after the storm the U.S. Public Health Service, a component of USHHS, has been on the ground since the storm, is still on the ground, and they have been miracle workers in my view anyway. And also CMS, right after the storm, worked with Tulane and LSU to deal with some of the graduate medical education vagaries as a result of our facilities being wiped out.

There are numerous other issues that we have enumerated, but there has been some help, yes.

Mr. HIRSCH. Mr. Chairman, after the storm, when Touro closed and as we were starting to reopen, we actually had the help of the Public Health Service, we had the 82d Airborne which was invaluable, we had some National Guard. We also had others to help us,

and from FEMA, we had the DMATs. I think part of the problem was they left before the population came back but they were helpful while they were there. But that was way, way, way before we had population. Colleagues mentioned some of the other aspects with Secretary Leavitt and some of the other issues; and then I think just recently with the staff of this committee coming, and I think once before there was another group that came in to interview us and that is at least for me why I am here today.

Mr. MELANCON. Well, if I remember correctly, we are over 18 months since the storm and so what I am gathering here is that immediately they came in and said we are here to help you but you really haven't seen any help since that. Would that be an honest expression?

Mr. HIRSCH. Well, I think people—

Dr. QUINLAN. Are hard at work but they are stuck.

Mr. MELANCON. OK.

Dr. MILLER. The one agency, Congressman, that needs to be lauded, it is not directly related to our patient care mission but certainly health care in general is the National Institutes of Health who were there from the beginning, have supported the academic missions of Tulane, LSU, and the other institutions that do research including Ochsner have been at the forefront, they have been there for us, and they have come through. So I want to make sure they get credit for that.

Mr. MELANCON. Dr. Quinlan, you said they were stuck. Can you elaborate on that?

Dr. QUINLAN. Well, we have been to a number of meetings in which many of the principals were at the table with the express purpose of bringing resolution to some of the problems we had, but it was unfortunately a continuing story of why they couldn't do things as opposed to how they would get it done and that is—this idea of flexibility, the idea of having rules which are appropriate to the situation as opposed to generic national rules. I think they were as frustrated as we are by the process, and that is where the idea of the goal of bringing people together in a non-partisan way, that there are some solutions that need to be crafted with the administration and Congress working together to make sure that these rules that were created years ago are actually appropriate for today's problems.

Mr. MELANCON. Yes, and I think if my understanding is correct the way the system works the Secretary of the Department has the ability to waive rules in special instances. Of course the inference that I have been getting is this sets a precedent. The precedent has been set. The storm was a precedent.

Dr. QUINLAN. Yes. If that isn't a precedent-setting event, I don't know what is.

Mr. MELANCON. Yes, I agree with you. And I am going to submit into the record some numbers that came from—Gulf Coast recovery numbers—some of the frustration, so that my committee members will know, there was some legislation in some of these appropriations that provided that no State could get more than 54 percent of the monies that were appropriated regardless of the fact whether we had 80 percent or not. There is monies that I think people need to understand, there are three words, one is appropriated, one is

allocated, and the other is expended. Appropriated and allocated are the most common you hear, expended is the one you hear least. As of February 5, out of \$110 billion, about \$52.8 billion, and this is across the board from the Federal Government from our appropriation, has hit the ground where it counts, and that is where the people are struggling. We have done disaster cleanup, we have—Small Business Administration—do you want to hear some really poor statistics? Dr. Bertucci was talking about it. SBA has received 224,000-plus applications, 102,000 and some change of which were declined, 87,000 loans have been approved, and only 62,000 loans have been disbursed, totaling \$2,932,000 since the storm, and SBA was allocated \$1.7 billion.

Let us talk about the Collaborative if we can real quick. The three private hospitals. Each of you suggested that one way to solve the health care access in the region is to reprogram the disproportionate share monies. How can we do this specifically, and we can't go on long because of time constraints. But how can this be done and what rules or laws need to be changed at both the State and the Federal levels in order for us to accomplish this?

Mr. MULLER. Let me just start and again emphasize the Medicaid proposed rule to come directly to the providers, us certify the uncompensated indigent care, and have the money come direct, don't go through the State. That would be real easy to do.

Mr. MELANCON. OK. Would you all have any problem—as I appreciated this \$250-\$300 million are getting left on the table because of Big Charity being down. Let me walk through this thought. I don't want to take away the money and then have some of the concerns that have been expressed here. But if there is some way to put a sunset over a period of time and allocate only that money for the use, with that sunset coming and of course if the time is passed and everything is gone—what I am trying to figure out is how do I get this Big Charity building off the table so that we can move forward with health care and planning for an education facility and a safety-net facility, whatever it may be? And that is where I am trying to get. I don't want to take control over the State legislature or the Governor, whoever he or she may be, and start dictating what they need to do in the State of Louisiana. So is that some commonsensical or is that a problem? Mr. Smithburg, let me start with you because you got the most at stake here.

Mr. SMITHBURG. Well, certainly I am continuing to get traction on that VA Collaborative is, I think, paramount in addition to—and I agree with Dr. Quinlan—getting primary care system up and running. For some reason, health care redesign has been morphed into what do we do with the Big Charity Hospital and the system therein? They are two totally separate issues.

Mr. MELANCON. Right.

Mr. SMITHBURG. And I think to the extent you can keep those separate as you have suggested, I think the better for all of us.

Mr. MELANCON. I thank you. Any other comments on that? And I agree. And that is where I am trying to get. I think that is the way we make these incremental steps is to put that big building, because that seems to be the problem or the mindset, off on the side as we work on the immediate problems.

It looks to me like restructuring the State's disproportionate share monies will funnel at least some resources away from the State's charity system in the near term, and I have that concern as I have expressed that your hospitals may not pick up your fair share of the truly sick, even if the DSH dollars follow the patient. Of course, the expression of cherry pick has been put out there. I am new to the health care arena, but I am starting to understand; and I need a firm commitment that you are not going to be turning away people if we work out the DSH dollars and the services that need to be applied in the area.

Mr. MULLER. I will make that commitment for West Jefferson. I can't speak for anyone else, but we are doing it, our board—and I know Dr. Quinlan said here they are here but until we run out of money, we are going to be there taking care of every patient that walks in the door.

Mr. HIRSCH. I will just say for Touro, we have been doing it for 154 years, we will continue to do it; and we do it by the laws of morality. When people come into the emergency room, our doctors treat them irrespective of their ability to pay and will continue to do it. And plus, it is the law of the land. But we do it because it is the right thing to do.

Mr. MELANCON. The ER room is different.

Mr. HIRSCH. Right, but if there is a system of care in place that we can participate in, absolutely, we will participate.

Mr. MELANCON. Then can I ask, is there some method that we can document and track this money over time so that we are making sure that we keep all the players honest.

Dr. QUINLAN. We have to do that to be credible but I—the dollars follow the patient is such a nice phrase, but I would like to add it has to be enough dollars follow the patient because what we don't want is this—

Dr. QUINLAN. Well, it is an idea where it looks good and let us walk away from it. If there aren't enough dollars, then all this begins to fall apart.

Mr. MELANCON. Yes. My time is running out. We have got votes I think we have got to go take. But let me ask you. You had the Collaborative. It was sent, it was supposed to deal with region 1 of the State of Louisiana, and what we were going to do to try to get that area of the State back up. If I understand it, all of you were at the table participating in that original Collaborative, butted heads, knock-down, drag-out—I have got a nodding no. But the Collaborative went to DHH. So what you are saying is no, you weren't involved in the—

Dr. QUINLAN. We weren't butting heads, it was a very collegial approach. It was a clear—

Mr. MELANCON. Well, I—

Dr. QUINLAN. No, I am serious. We often think that it was some sort of conflict. The need was so great and our common interests were so great—yes, we wrung our hands because the question is do we have enough to get the job done. And we were not given the task with enough information to address the broader question. That is why it ended up being a medical home issue. And it did become—our direction became something that had to work with the

State and as we reconstituted this, we wanted to go back to region 1 and have something that we could be more specific about.

Mr. MELANCON. Yes, and I have got some further questions but we need to go and vote. I want to thank you all for being here; and if there is any contact or expressions that you need to make to myself or staff, please do not hesitate. We are going to try and work through this thing over a period of time.

I will turn the chair back over.

Mr. STUPAK [presiding]. As Mr. Melancon said, we do have to vote on the floor. We have 7 minutes left to vote, so we are going to recess for one-half hour before our last panel.

Thank you all for coming. We will see you all back in about half-hour.

[Recess.]

Mr. STUPAK. The subcommittee will come to order.

We are ready for the next panel. The Honorable Leslie Norwalk, Acting Administrator, Centers for Medicare and Medicaid Services, Washington, DC; Dr. Fred Cerise, secretary of the Louisiana Department of Health and Hospitals; Dr. Robert Lynch, director of the South Central Veterans Affairs Health Care Network; and Dr. Kevin Stephens, director, City of New Orleans Health Department.

As is customary for the Subcommittee on Oversight Investigations of the Energy and Commerce Committee, I will ask you all to rise and take the oath.

[Witnesses sworn.]

All witnesses answered in the affirmative. We will start with Ms. Norwalk, Acting Director for Centers for Medicare and Medicaid, for 5 minutes, for an opening statement,

**STATEMENT OF LESLIE NORWALK, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES**

Ms. NORWALK. Thank you, Mr. Chairman, members of the subcommittee. On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans near Gulfport, Mississippi. The storm's tremendous impact was exacerbated by the failure of the Lake Pontchartrain levee around New Orleans on August 30. With the added blow of Hurricane Rita on September 23, 2005, more than 4 million people were evacuated, tens of thousands of businesses, and over 100,000 homes were destroyed. Over 685,000 families were forced to relocate, and at least eight hospitals were ruined. Over 1,400 people died.

While the storms were devastating and tragic, Louisiana has the opportunity to embark upon implementing the most far-reaching improvements in their health care system since the charity system was created hundreds of years ago in the early 1700's. The health care system in New Orleans is in essence two systems, one for the insured and one for the uninsured. There have been a series of reports and studies both pre- and post-Katrina that address the deficiencies of the health care system in Louisiana. There may be debate on the detail, but I would say that most everyone agrees the system is broken and needs attention. It is time to level the playing field and provide the poor and uninsured the same opportunities that those fortunate enough to be insured have, the ability to receive quality care and choose their own health care provider.

The infrastructure, economics, and premise of the way the poor are served in the charity system is outdated and no longer aligns with today's health care environment. What better way to roll out a new system of care than to start in the great city of New Orleans and then extend it to the entire State? This will require a major educational effort and cultural change, but I believe as many others do that all Louisiana citizens will benefit from a new health care system.

The public health and medical crisis across the Gulf Coast required immediate action to prevent the further loss of life. Medicare and Medicaid are health insurance programs, however, and were not designed for disaster relief. This, combined with the extent of devastation in the region, posed significant challenges. On August 31, 2005, Secretary Leavitt declared a Federal public health emergency for the Gulf Coast region permitting CMS to waive program requirements to ensure the region's health care needs could be met. CMS proposed to—proceeded to waive modify certain Medicare and Medicaid conditions of participation, certification requirements, and pre-approval requirements which enabled the remaining health care infrastructure to deliver vital services.

CMS also quickly established a special multi-State Medicaid demonstration to help ensure continuous access to health care services for displaced hurricane victims. Individuals contemporarily enroll in Medicaid or SCHIP in host State and receive benefits for up to 5 months. In addition, the Deficit Reduction Act gave CMS authority to pay the non-Federal share of regular Medicaid and SCHIP expenditures in certain counties and parishes.

Finally, States were able to participate in an uncompensated care pool to help cover medically necessary services for evacuees without health insurance coverage.

By January 31, 2006, CMS had granted approval to a total of 32 States or territories to participate in these demonstrations. Of those, eight were also approved for the uncompensated care pool.

Turning now to funding, HHS has made available more than \$2.8 billion in Katrina-related funding in fiscal year 2006 to help respond to the health-related needs of people affected by the disaster. This includes \$2 billion appropriated by the DRA for payments to eligible States. To date, over \$1.75 billion has been made available to 32 States for a range of health care items and services, associated administrative costs, uncompensated care costs, and Medicaid and SCHIP costs in the immediately affected Gulf Coast region.

Last month, HHS also made available an additional \$160 million for payments to facilities facing financial pressure because of regional wage changes not reflected in Medicare payment systems. Finally, on March 31, just a couple of weeks ago, CMS provided a \$15 million grant to promote professional health care work force sustainability in the greater New Orleans area.

I want to emphasize that when we distributed these funds among the States we first consulted with them on their needs and provided funding based on their requests. Specifically we have provided \$831.6 million to Louisiana. Of this amount, Louisiana used \$130.9 million to pay providers for claims under its uncompensated care pool. The vast majority of funds provided to Louisiana, nearly

\$700 million, was through section 6201 of the DRA. This money was used by Louisiana to pay its matching obligation under the State Medicaid Program. By relieving Louisiana of its Medicaid obligation, it is effectively freeing up the mountain of State funds.

Although the challenges of addressing Louisiana's immediate and longer-term health care needs have been daunting, they present real opportunities. Working together, we have the opportunity to transform the Louisiana health care system. A recent Public Affairs Research Council describes the system as "outdated and uncommon, a system that begs for reform."

The great tragedy and challenges brought by Katrina galvanized a unified movement to improve health care for the people of Louisiana. CMS has been an active partner in this effort from the outset providing dedicated staff, technical advisors, access to data, and other assistance to assist Louisiana in a health care redesign collaborative and developing a practical blueprint for evidenced-based, quality-driven health care system in Louisiana.

The Collaborative unveiled its blueprint with a concept paper on October 20, 2006, and CMS has been working steadily with them since that time to clarify key elements. CMS and HHS have pledged support for a large-scale Medicaid waiver and Medicare demonstration to bring about the Collaborative goals, provided they are consistent with our mutually agreed-upon principles for rebuilding.

CMS will continue to engage the State in discussions over how the demonstrations and waivers might be structured and make expertise available to assist in their efforts.

Thank you and I look forward to answering whatever questions you might have.

[The prepared statement of Ms. Norwalk appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Ms. Norwalk. Dr. Lynch, please, for 5 minutes.

STATEMENT OF ROBERT LYNCH, M.D., DIRECTOR, SOUTH CENTRAL VETERANS AFFAIRS HEALTH CARE NETWORK

Dr. LYNCH. Mr. Chairman and members of the committee, I want to start by thanking you for the universal support the U.S. Congress has given to the Department of Veterans Affairs in its rebuilding and recovery efforts not only in southeastern Louisiana but along the entire Gulf Coast region. Through that support, our veterans and the VA employees living along the Gulf Coast continue to make great strides along the road to recovery.

Hurricanes Katrina and Rita challenged our country with two of its greatest natural disasters. While Hurricane Rita did little permanent damage to VA's infrastructure, Hurricane Katrina, on the other hand, produced unprecedented damage to its medical center in New Orleans. Our medical center, the community we serve, and the homes of veterans and employees sustained destruction on a monumental scale.

Today I will describe our ongoing and planned health care restoration efforts in New Orleans. I will speak first to VA health care recovery activities and its future plans in New Orleans. Next I will address the Memorandum of Understanding that was signed be-

tween VA and the Louisiana State University System and actions associated with it. Finally I will discuss VA's relationship with LSU and the State of Louisiana as the State of Louisiana progresses in its analysis of State health care reform.

Forty-eight hours following Hurricane Katrina's landfall, as quickly as weather conditions permitted, the VA damage assessment team was dispatched to the Gulf Region to survey the eight facilities at New Orleans, Louisiana, Biloxi, Mississippi, and Gulfport, Mississippi. At New Orleans, the team found the VA facility initially weathered the storm with minimal damage. However, following the hurricane, water from the breached levees flooded the entire medical district and the medical center. Flooding of the basement and the sub-basement in the main building of the VA Medical Center rendered it inoperable as these areas housed the facilities, major electrical, mechanical, and dietetics equipment.

The Medical Center's longstanding academic partner, the LSU Health Care Services Division, had Charity and University Hospital sustain similar types of damage. While University Hospital has reopened, Charity is permanently closed.

In the immediate aftermath of Hurricane Katrina, VA's commitment to the Gulf Coast region's veterans remains steadfast. VA deployed a system of 12 mobile clinics, in coordination with local authorities, to provide urgent and emergent care to include first aid, immunizations, and prescriptions. Specifically in Louisiana, mobile clinics provided care at Baton Rouge, Hammond, Jennings, Kinder, Lafayette, Lake Charles, Laplace, and Slidell. Those VA mobile clinics treated 5,000 veterans and over 11,000 non-veterans in the aftermath of Hurricanes Katrina and Rita.

To address the health care of veterans in the greater New Orleans area, the VA expanded the capacity of its existing community-based outpatient clinic, or CBOC, in Baton Rouge. We converted the ninth and 10th floors of the Medical Center, formerly the Nursing Home in New Orleans, into exam rooms and began offering primary care services there in December 2005. Three months later, in March 2006, limited specialty care clinics were also added to those units.

Temporary facilities located in Laplace, which is in St. John's Parish, and Slidell were leased as an alternative—as alternative sites of care. Tents were erected in Hammond to provide basic services.

With the support of Congress, the VA was authorized to accelerate the activation of community-based outpatient clinics where part of our capital asset—long-term capital asset plan and opened a permanent clinic in Hammond in August 2006. We remain in leased space in Slidell and plan to construct a permanent clinic there in 3 to 5 years. The St. John's community-based outpatient clinic is anticipated to open in October 2007.

Basic outpatient mental health services are provided at each of the clinic locations. Currently inpatient mental health services is coordinated with the Alexandria, Louisiana VA Medical Center. Dental clinic services were re-established in April of 2006 by leasing space in Mandeville, Louisiana. In Baton Rouge, we leased the old clinic building there in 2006 and are using that facility to house

the medical center's clinical laboratory as well as select administrative support functions.

As a result of these actions, the southeast Louisiana veterans' health care system, formerly known as the New Orleans VA Medical Center, served over 29,000 veterans in fiscal year 2006. This is 72 percent of the previous year's workload in the year before Hurricane Katrina. In fiscal year 2007, workload to date is growing at an annualized rate of 10 percent over last year and is expected to increase as housing is restocked in the area.

To help our staff and support the community, VA worked with its academic affiliates, Tulane University School of Medicine and the LSU School of Medicine to place VA faculty, medical staff, residents, and student trainees at VA medical centers throughout our Business 16 network. With the VA's inpatient units shut down, 102 medical center employees that includes nurses, health technicians, medical support assistance, operating room technicians, and certified registered nurse anesthetists and radiology technologists were temporarily deployed in July 2006 under a FEMA task order to provide critically needed staff to support local health care institutions.

In terms of future VA services in New Orleans, we continue to explore our long-term options for re-establishing surgical capabilities and inpatient services in New Orleans. In the interim, these services are coordinated through sister VA medical centers in Louisiana, Mississippi, and Texas, as well as selective referrals to community hospitals in the New Orleans area at VA expense. We are actively pursuing options for expanding our outpatient mental health services as well to meet both current and future veteran needs.

Projects for the re-establishment of radiology and outpatient pharmacy services on the grounds of the old medical center are under way and expected to be completed later this calendar year. In preparation for the construction of a replacement medical center, VA has initiated its space planning process. Interviews of architecture and engineering firms to design the new facility are complete. A selection is expected this spring. The replacement medical center is expected to provide acute medical, surgical, mental health, and tertiary care services as well as long-term care.

As required by Public Law 109-148, VA compiled and presented its long-term plans for the construction of a replacement hospital in New Orleans in February 2006. That report is entitled "Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans". In that report, VA identified its principal objectives regarding the New Orleans area as being not only to restore services to Veterans in the most cost-effective manner but also to assist in the restoration of health care and medical education in New Orleans. Recognizing the successful history for sharing and collaboration between VA and LSU health care services division, as well as the potential for future efficiencies, the report included the construction of facilities on a single campus with support services shared with LSU was the preferred option.

As a result of the report, VA and LSU leadership signed a Memorandum of Understanding agreeing to jointly study state-of-the-art health care delivery options in New Orleans. This MOU established

the foundation for developing a collaborative approach to operating a replacement facility.

From that, a group of experts from both organizations, called the Cooperative Opportunity Study Group, or COSG, was charged with determining if any mutually beneficial sharing could occur between the two organizations. In the group's June 2006 report delivered to the former VA's Under Secretary for Health, it concluded that both organizations could leverage their strengths, provide significant operating efficiencies, and allow us to better serve our beneficiaries. Congress subsequently authorized VA to pursue the project to replace the New Orleans facility as a collaborative effort consistent with the COSG report.

In September 2006, the Collaborative Opportunities Planning Group, or COPG, was established to develop an operational plan for sharing between the organizations based on the foundations of the COSG. The COPG is co-led by VA and LSU representatives, representatives of the Tulane University School of Medicine and the State of Louisiana Division of Administration are also part of this group and its planning discussions.

A critical component of the charge of the COPG is to determine if the proposed sharing options identified in the regional COSG report are viable, and if they are, to begin the work of developing timelines and formulating the framework for space planning and design for a joint replacement facility. To date, the COPG has made significant progress by reviewing literally dozens of clinical and administrative functions to determine if the function would best be provided via a sharing arrangement, between VA and LSU, or independently owned and operated by both entities.

The final report of the COPG is to be presented this September.

Mr. STUPAK. Doctor, can you summarize, please?

Dr. LYNCH. Yes, please. VA remains excited about the MOU with the LSU in the context of health care redesign in Louisiana. We support all the principles behind it. At the same time, health care redesign seems to face some obstacles and delays in Louisiana. Because of this, we are committed to exercising due diligence to our veteran beneficiaries and to the taxpayers and are concurrently exploring other options for initiating reconstruction of our VA Medical Center in southeast Louisiana. In furtherance of this, we plan to begin a site search to identify alternative locations in the near future while we continue our work with LSU on our collaborative plans.

In conclusion, Mr. Chairman, we consider the committee and Louisiana delegation to be partners with VA and seeing the southeast Louisiana veterans continue to receive high-quality health care that they have come to expect and deserve. Congress appropriated over \$1.2 billion supplemental funding for recovery and rebuilding efforts in VA. This includes \$625 million for the construction of our placement medical center in New Orleans.

Our commitment to outstanding health care for veterans will continue as well our collaboration/exploration with LSU.

Thank you for the opportunity to be here today. I appreciate it, and I will take the opportunity to answer any questions.

[The prepared statement of Dr. Lynch appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you. Dr. Cerise.

**STATEMENT OF FRED CERISE, M.D., SECRETARY, LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS**

Dr. CERISE. Thank you, Mr. Chairman, and members of the subcommittee for the opportunity to testify today on the continuing concerns and immediate health care needs in the New Orleans region.

Let me start by saying I have heard Congressman Dingell's directive earlier this session and commit to you that I will call Secretary Leavitt's office upon leaving here today and discuss follow up of this discussion that we are having here.

You have heard much about the loss of compassion in the health care delivery system in the New Orleans region, from preventative services to acute care, hospital services to post-acute and long-term care services.

Our challenge is twofold, to first meet immediate needs while second, ensuring that in the process we support the rebirth of a better overall system of care, particularly in the Katrina and Rita affected areas. This vision is for a system to replace the loss capacity. It is one that adheres to the aims set forth by the Institute of Medicine. It is a patient-centered system predicated on access to primary care coordinated among providers, supported by a system of electronic medical records to improve safety, quality, and efficiency.

The current gaps in the delivery system created by Katrina have provided the opportunity for that type of system's change. As we move forward with the health care reform for Louisiana, we must also ensure that the New Orleans region can recover to meet our citizens' health care needs today.

My testimony today will focus on the short-term health care needs in the New Orleans region. Louisiana appreciates the assistance Congress has provided for health care. For example, \$680 million in Medicaid relief and \$134 million in uncompensated care reimbursement which came at a critical juncture in early 2006 as the State was implementing budget cuts in almost all programs including health care. The State actually had a rule that we had issued cutting reimbursement payments to Medicaid providers by roughly 10 percent across the board.

Subsequently the State has been able to provide assistance including \$52 million in uncompensated care for community hospital services rendered during fiscal year 2006, \$120 million in uncompensated care for community hospital services during State fiscal year 2007, \$38 million to increase Medicaid payments to hospital and in an attempt to sustain capacity for post-acute care, direct service workers caring for elderly and individuals with disabilities in the Medicaid program received a \$2 an hour salary increase at an annualized cost of \$110 million.

Still more assistance is needed to meet the extraordinary needs that we are faced with. I am going to summarize a few areas. You have heard about these earlier today as well.

Primary care capacity. Using Federal standards, we have a shortage of 49 primary care physicians in the New Orleans region available to serve the Medicaid uninsured population which is af-

fecting all other components of the system. We propose to establish primary care capacity in a manner consistent with the redesigned system of care envisioned by the Health Care Redesign Collaborative by sustaining operational support provided by SSBG funds to safety-net clinics and by funding new medical homes of sufficient size and scope to meet the needs of the uninsured population.

Still roadblocks to increasing access to outpatient care include the inability to use disproportionate share, or DSH, funding for non-hospital based care and the inability to use DSH to reimburse for physician services remains an issue. In order to receive DHS funds today, health care services must be funded through a hospital. While the State has created great capacity in a clinic system associated with public hospitals, current DSH rules limit flexibility and development of further outpatient capacity.

We propose that the State be allowed flexibility to use DSH funds to support non-hospital based clinic care and allow DSH funds for physician services. This solution does not require additional Federal funding, just flexibility.

In terms of workforce recruitment retention, you have heard a lot about this already. The New Orleans region is experiencing shortages of physicians, behavioral health providers, nurses, other professional staff, and competition for workers is high including rising labor costs, lengths of stay in hospitals are increasing. I would point to two solutions. You have heard about one in terms of the Medicare wage index. The Medicare calculations do not account for the unforeseen labor cost increases seen in the region post-Katrina. HHS awarded Louisiana \$71 million one-time grant to address this. That is certainly helpful. Hospitals and skilled nursing facilities estimate this is about one-third of the need to address this increased wages relevant to the Medicare program.

Second, to date the State has received a \$15 million grant from HHS to fund the Greater New Orleans Health Services Corps to provide incentives for physicians, dentists, nurses, and other professional staff to meet the needs in the region. We requested funding for this program. We think that program would cost—our estimates are \$120 million to fully supply and meet the needs in the region today, and so we would ask for that support. In exchange for the financial support, providers must commit to serve in that region for 3 years.

And then finally in the area of behavioral health, the shortage of community services that we had prior to Katrina was exacerbated by the hurricane resulting in greater reliance on an already-crowded hospital emergency infrastructure. In addition, we have lost psychiatric beds in the area. We propose funding and implementation of a 5-year plan for behavioral health services and expanding Medicaid coverage to people with severe mental illness. This 5-year plan would include direct treatment dollars for the full continuum of behavioral health care as well as continued funding of the existing FEMA disaster relief grant for crisis counseling.

The concept paper put forward to HHS also included a request to include those individuals with serious mental illness as a Medicaid eligible population. This would allow us to provide broader access to services for these individuals.

I have outlined other needs in my written testimony, including such things as support for implementation of electronic records as was pointed out earlier today, as well as section 8 housing vouchers to be used with permanent supportive housing for people with developmental disabilities.

I appreciate your continued interest in the recovery of the greater New Orleans region. The State has worked collaboratively with Federal the city officials as well as community providers, and I have heard your directive earlier today and commit to continue this work to address those critical needs highlighted today.

Thank you for the opportunity to testify.

[The prepared statement of Dr. Cerise appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you and thank you Dr. Cerise. I noticed you have been here all day, so I appreciate that. Dr. Stephens?

**STATEMENT OF KEVIN U. STEPHENS, SR., M.D., DIRECTOR,
CITY OF NEW ORLEANS HEALTH DEPARTMENT**

Dr. STEPHENS. I am Dr. Kevin Stephens, the director for the New Orleans Health Department. To Chairman Stupak and the Ranking Member Whitfield, and distinguished members of the Subcommittee on Oversight and Investigations, thank you for inviting me here today to speak on the state of health care in New Orleans. Mayor C. Ray Nagin and his administration welcome dialog, and we are hopeful that this hearing will spur positive change as we work not only to rebuild our city's infrastructure and neighborhoods, but also to develop a state-of-the art, modern health care delivery system.

I would like to acknowledge and thank Secretary Michael Leavitt who was represented by Ms. Norwalk, for all the support that the Department of Health and Humans Services has given to the City Health Department specifically. And in fact, Secretary Leavitt—I first met him on August 24, 2005, less than 1 week before Hurricane Katrina. We both visited the Pontchartrain Senior Citizen Center and spoke with community leaders and senior citizens about Medicare. We developed a professional relationship which has continued in the aftermath of Hurricane Katrina, and additionally I would like to thank Dr. Cerise for his support of this city as well as Dr. Lynch of the Veterans Affairs; and we are looking forward to having a long, productive relationship with the Veterans Affairs and we are looking to strengthen our partnership with them.

I want to just three or four things here, talk about the pre-existing problems and Katrina's impact on it, the role of the New Orleans Health Department, mental health, and some recent mortality trends that we have observed.

Since the storm and floods, only four of the eight hospitals in the parish have reopened at decreased capacity. The City Health Department which employed more than 200 health professionals lost more than 60 percent of its staff and closed eight of its clinics. Yet, as traumatic as this devastation was, it has given us a unique opportunity to redesign and rebuild a model health care delivery system that corrects the gaps and failures of the past.

The New Orleans population, which was more than 450,000 people before Hurricane Katrina is now estimated to be between 230,000 and 250,000 citizens. Even with this temporarily reduced population, approximately 20 percent of our citizens or more than 30,000 people are uninsured. The city has a rapidly increasing indigent worker population, some of which speak no English. In providing health care services, these citizens has placed such a tremendous burden on our health care providers of the surrounding parishes and those that are in New Orleans.

Another challenge has been the decrease in the number of health care providers. According to a 2006 Blue Cross/Blue Shield report, New Orleans had 2,038 physicians pre-Katrina and only 510 physicians post-Katrina. This is a 72 percent decrease which highlights the relative loss of medical professionals. Other evidence can be found in a study conducted by the Louisiana State Department of Health and Hospitals where out of 202 primary physician who responded, only 154 were still practicing, and only 73 accepted patients dependent on Medicaid as a source of payment. Clearly, more providers are needed in Orleans Parish, particularly those who care for the uninsured and underinsured.

There is a similar story as it pertains to the capacity of Orleans Parish hospitals. According to the 2006 report by PriceWaterhouseCooper, New Orleans had 2,258 beds before Katrina and according to a recent report by Metropolitan Hospital Association, Orleans Parish now has 625 staffed beds, a reduction of 75 percent.

Fortunately, our neighboring Jefferson Parish, they have lost far less capacity; and with its number of hospital beds decreasing from 1,922 to 1,636, Jefferson Parish hospitals have been responsive in absorbing patients from Orleans Parish. But this not negate the critical need for more hospital beds to open in Orleans Parish and to meet the needs of our ever-increasing population.

The City of New Orleans Health Department must play a significant role in improving the health of the residents of our city. We need to full staff our clinics and expand the offering to include all preventative and primary care services. Since health outcomes are largely controlled by personal lifestyle choices, public health professionals must play a critical role in educating the public about health risk and behavior modification. We think this is the ultimate solution because that is how you really decrease primary care—and hospital beds is by getting people to change their personal lifestyle choices.

Mental health, the provision of mental health services pose a particular challenge in this region, an that has experienced severe loss, death, and destruction. And so we think that despite this need, it has fewer than 50 hospital beds for inpatient psychiatric care, about 17 percent pre-Katrina capacity.

And finally, the mortality rates, as a doctor and health care provider, I noted a dramatic increase in the number of death notices in the newspaper. This observation was supported by further deaths of two of the staff people of my own department within a short period of time and anecdotal accounts of families going to more funerals than ever. Due to the lack of State data for this problem, we engaged in a count of death notices in the Times-Pica-

yune and compared it to a parallel period before Hurricane Katrina.

To validate our methodology, we compared the number of deaths notices printed in the newspaper in 2002 and 2003 compared to the published State data from death certificates. In both cases, we noted the difference between the two was not statistically significant. In 2003 we averaged 924 deaths per month according to death notices. In contrast, for the first 6 months in 2006 we averaged 1,317 death notices per month. This means that approximately 7,902 citizens expired within the first 6 months of 2006 as compared to 5,544 for the first 6 months in 2003. The observations as well as the severity of health problems treated in our Health Recovery Week strongly suggest that our citizens are becoming sick and are dying at a more accelerated rate than prior to Hurricane Katrina.

We believe these findings are significant, but the city has reached its limits as to its ability to research this important issue. It is critical that the State and Federal agencies immediately study these trends as well as the cause of death. This information can be used to develop appropriate intervention.

In conclusion, clearly the health care system in New Orleans is far from normal, and we are working diligently to make improvements. The City of New Orleans Health Department has three proposals to comprehensively and systematically rebuild our health care system.

Number 1, all citizens should have immediate access to primary, preventative, and mental health care services. People are suffering now and we must respond.

Number 2, the city needs more hospital beds. The shortage of hospital beds has reached a crisis proportion and on some days ambulances have to wait hours on emergency room ramps to offload patients.

Number 3, we must receive the resource to rebuild the New Orleans Health Department. Our Health Department is a necessary partner in the repair and reconstruction of the city's health care delivery system.

Our health system has serious inadequacies and gaps prior to Hurricane Katrina, but the storm ruptured it to a point that many more of our citizens have lost access to health care services.

I would like to thank you for your attention to New Orleans, and we look forward to working with you to solve these problems.

[The prepared statement of Dr. Stephens appears at the conclusion of the hearing.]

Mr. STUPAK. Thank you, Dr. Stephens. Doctor, if I may, you indicated and I was a little surprised by the statement that the number of deaths since Hurricane Katrina was not statistically significant, yet we have had another panel say they are up about 48 percent. I think if you look at the Times-Picayune newspaper obituaries before Hurricane Katrina, you had about 30 a day. Now you are averaging about 60, 61 a day. That is a rather significant increase in the number of deaths per month since Hurricane Katrina.

Dr. STEPHENS. Yes, and I said they have been significant. I didn't say they were insignificant.

Mr. STUPAK. Then I must have misunderstood you. My apologies if I did. Let me ask you this. In the Times-Picayune, there was an article, Friday, March 10, about the trailers that came 9 months ago. There are eight exam rooms that were supposed to be strategically deployed around the city and we are still waiting for a permit. Can you tell me what is the status of that?

Dr. STEPHENS. Well, the permitting is not in the prevue of the Health Department—

Mr. STUPAK. I realize that.

Dr. STEPHENS. I can tell you what I know.

Mr. STUPAK. OK.

Dr. STEPHENS. In the city council meeting a week ago they passed the zoning variance they needed for the placement of the trailers in the school zone.

Mr. STUPAK. We are all set to put those trailers out there?

Dr. STEPHENS. Well, I am not sure where they are in the process. I know they got the biggest hurdle which is getting it through city council. But as I reflect back upon it, a couple things, one—

Mr. STUPAK. You have to provide a certificate as public health?

Dr. STEPHENS. No.

Mr. STUPAK. OK.

Dr. STEPHENS. I have nothing to do with that process at all. But when it came to my attention, I did go and ask what we could do to help.

Mr. STUPAK. Dr. Cerise, there was a question earlier or a statement earlier about the nurses, volunteer nurses coming in. I think it was with Operation Blessing where at the end of the month they can that be resolved between now and then end of the month?

Dr. CERISE. Listening to the earlier testimony, I checked with the Board of Nursing and the process—and they are not aware—they are not denying nurses access to the area. Unless there is a credentialing problem, inability to verify credentials or something like that, they are not doing that; and they told me that they don't have plans to do that.

Mr. STUPAK. Would you get Mr. Koehl after this and get this thing—

Dr. CERISE. We will make sure we make clarify that. And if I could on the death rate, we did our office of Vital Statistics did look at this a little bit over a year after Katrina, and it is tough to come to a rate when you don't know the population for sure. And so we were able to do some comparison before in 2004–05 and 2005–06 and the number of deaths of people from New Orleans who are residing in Louisiana, where we would have a death certificate on them, was about 41 percent of the deaths in a prior year period. We also have that broken down by cause of death and we—

Mr. STUPAK. Right, but I understand we have less people now in New Orleans than we did before. So if it was 31 deaths before with a full New Orleans and now we got half of New Orleans and we got 60 deaths, that is a tremendous—

Dr. CERISE. That is where I said the difficulty is with a moving population, but looking at absolute numbers, it was about 41 percent a year after.

Mr. STUPAK. Would you work with Dr. Stephens to get that one resolved? Ms. Norwalk, in your testimony on page 4 you indicate

CMS established a special 1115 Demonstration Waiver Program to help insured, continuity of health care services for victims of Hurricane Katrina, basically the evacuees, correct?

Dr. CERISE. Absolutely.

Mr. STUPAK. Why can't we put a program—

Ms. NORWALK. That is the way that the DRA funds work it—

Mr. STUPAK. Why can't we do a special demonstration project, waiver 1115 for all of New Orleans right now? We have a number of things besides money. We have community health centers that have been applications pending before Hurricane Katrina struck still not approved. We have got the volunteer nurse issue which I think we might have resolved. We have an underserved area, we need health information technology, we need PATH to specialty services, workforce development, you name it, we got a number of problems. Why can't we get together and do a special demonstration project because things are not very well here in New Orleans?

Ms. NORWALK. Well, that is what we have been working with the State to do, in fact, is to work both on a Medicaid waiver as well as doing Medicare demonstration.

Mr. STUPAK. OK. But you rejected The Cooperative plan which is really for region 1, wasn't it?

Ms. NORWALK. Well, it was a concept paper that was submitted by the State on behalf of the Collaborative. I wouldn't say that we rejected it. We had been working with the State to figure out what it is that the State wants to submit. I can ask Fred if that was a waiver that was submitted or merely concept paper that—

Mr. STUPAK. Well, wasn't the Collaborative—wasn't that really sort of like to put a pilot program in region 1, those four parishes we have been talking about today to try to get health care delivery system as quickly as possible up in New Orleans?

Ms. NORWALK. We submitted our paper.

Dr. CERISE. What we were asked to submit was a concept paper by October 20 which we submitted for the New Orleans area. I think some of the earlier discussion has been in terms of the rejection of that. We are still in discussion with CMS on this issue.

Mr. STUPAK. What are the issues that have to be resolved? Our goal here is to get, like yours, is to get health care back to—what else has to be done here to get this region 1 Collaborative effort going here? What has to be done? What waivers do we need at both the State level and then we will go to the Federal level?

Dr. CERISE. We have stepped back—the State has—look, we put forth a concept paper and I apologize going into some detail but it is rather complex. We put forward a concept paper working in cooperation with CMS that said this is how you could insure the population in this region. And by using Medicaid savings, restructuring Medicaid, and shifting DSH funds to an insurance product.

Mr. STUPAK. OK. This was region 1, these four parishes?

Dr. CERISE. That is correct.

Mr. STUPAK. And HHS did not accept that?

Dr. CERISE. In discussions after October 20th we were told they would not do a region-specific demo—

Mr. STUPAK. But a statewide demo?

Dr. CERISE. It would be statewide. So we started working on a statewide number.

Mr. STUPAK. We shouldn't be worried about statewide situation right now.

Ms. NORWALK. Actually there are a couple points I would like to make to that. First in doing this—in fact it was Secretary Leavitt's initial proposal to do this on a region 1 specific basis or greater New Orleans basis.

Mr. STUPAK. Answer me this. The Secretary can't be happy with the health care system being delivered in these four parishes.

Ms. NORWALK. Absolutely. That is correct.

Mr. STUPAK. So why would you reject the Collaborative and come up with a statewide plan?

Ms. NORWALK. Actually we haven't and in my opening statement—

Mr. STUPAK. All right. You haven't rejected it, you haven't approved it.

Ms. NORWALK. They haven't submitted a waiver to us. They have submitted a concept.

Mr. STUPAK. Have you told them they have to submit a waiver with this Collaborative?

Ms. NORWALK. I think it is without question known that they need to submit a formal waiver.

Mr. STUPAK. Have you told the State that?

Ms. NORWALK. Yes, absolutely.

Mr. STUPAK. OK. Today or earlier?

Ms. NORWALK. Oh, this has always been the issue since we have been down there for a year-and-a-half that the State would need to submit a waiver to us formally as they do for other waivers that they have submitted to the Agency.

Mr. STUPAK. OK. Dr. Cerise did they tell you you have to submit a waiver to get this Collaborative effort in?

Dr. CERISE. We are aware that to get a waiver that there is a formal application process.

Mr. STUPAK. OK. Have you submitted that application?

Dr. CERISE. No, we haven't.

Mr. STUPAK. Do you anticipate submitting that application?

Dr. CERISE. What we anticipated doing was getting to a level of agreement so that we know when we would submit a waiver it would be an acceptable waiver. There is a lot of work that goes into that piece. And we were working with CMS to try to get to that point. It became clear to us in that process that the dollars needed to do what we were comfortable with, and that was insuring a significant portion of the population with existing funds, with no new funds. We are going to be much more than we had in existing funds. We were working through a number of assumptions with CMS. In about mid-December, those discussions stopped until we received essentially the set of spreadsheets that you referred to earlier in January.

Mr. STUPAK. So you are getting into an actuarial battle then, right, on cost, pennies, and things like this, right?

Dr. CERISE. That is correct.

Mr. STUPAK. That is what we don't have time for, right?

Dr. CERISE. That is correct.

Mr. STUPAK. OK. Here is what I am going to do on this Collaborative. We are going to ask HHS to provide us all documents going

back and forth. The committee has been trying to get our hands on it. So you can expect the document request from this committee on that. And so we ask you to preserve the documents and statements along those lines there.

Ms. NORWALK. If I can make just one comment, Mr. Chairman, about the issue about the issue of region 1 only.

Mr. STUPAK. Sure.

Ms. NORWALK. While it makes a great amount of sense to start in region 1, I want to note the disparities that would occur if that were the case. In region 1, if you said let us do this proposal and cover those who are 200 percent of the poverty level or below that would mean a family of four could be earning \$41,000.

Mr. STUPAK. That is fine.

Ms. NORWALK. It is great.

Mr. STUPAK. It is fine with me.

Ms. NORWALK. However, in region 5 that has been hit by Rita and actually a number of other regions, that same family of four could only earn \$2,600 in order to qualify for Medicaid under the same thing. That disparity is something that concerns us if it is long term. So when working with a statewide, appreciate rolling it out, region 1 is of what is critical importance to deal with New Orleans, there are issues that the State is going to need to consider because you wouldn't want an influx of people to New Orleans when the system is not yet ready to handle that from an infrastructure perspective. Not that it wouldn't be great medium term—

Mr. STUPAK. Well, my concern is region 5 has health care, region 1 does not. My concern is also there is a 115 waiver waiting, according to Dr. Wiltz, for 287 health care clinics that were before Hurricane Katrina and they are still not approved, right?

Ms. NORWALK. I don't now if that is a 115 waiver on—

Mr. STUPAK. Well, there is a waiver pending. I might have my number wrong.

Ms. NORWALK. I can check with staff. There may be something pending elsewhere.

Mr. STUPAK. Here is my concern. 9/11 hits New York, they have their waiver pending, that is approved, no questions asked, no further documentation. New Orleans, we have been waiting 18 months, even more than that, and we still have waivers pending before HHS not approved. When I was down in New Orleans a year ago and we asked the question about waiver that they needed then, I think it was for the GME, for graduated medical, and were told they filled out the wrong form. But you never told the people that. We are getting a little frustrated.

Ms. NORWALK. We actually did the GME in a rule so they wouldn't need a waiver for the future, and we have solved that problem for the next 3 years. So from a GME perspective, we have been verifying—

Mr. STUPAK. What can we do that is going to be unique? Why can't we demonstrate a project here? There is a great need here for health care.

Ms. NORWALK. Absolutely.

Mr. STUPAK. Why can't we get with HHS, get with the State, the city, and provide the reimbursements they need, the nurses, the clinics, and get this thing moving?

Ms. NORWALK. The other piece that I think is important to note is——

Mr. STUPAK. No, how about answering my question.

Ms. NORWALK. In answer to that question I am more than happy to sit down with you at any point in time.

Mr. STUPAK. I want you to sit down with the State, the city and them. I don't know about New Orleans.

Ms. NORWALK. We do that on a continual basis. We have been working with the State for pretty much every day. We have people embedded at the——

Mr. STUPAK. Very good. You want to make a statement there, though?

Ms. NORWALK. Yes, I did actually want to point out that the \$2 billion in DRA funding, the \$164 billion went to cover the evacuees and the State share as well as those who are impacted within Louisiana. Over the last month we have distributed \$175 million across the Gulf Coast region. \$71.6 million went to address the Medicare wage index's disparity with hospitals——

Mr. STUPAK. You can spare us the stats because all the other panelists told us there is not enough in the system. They are not getting the money. And you could have released \$2.8 billion but it all didn't go to health care, it went to many other places. Our concern is get health care up and running.

Ms. NORWALK. Just one other point is that there is some additional funds from the DRA. We anticipate about \$170 million as we collect that back from the other States that did not spend the DRA funds on impacted individuals and evacuees. We do intend as we can under the DRA to reallocate those funds, much like we did with the initial \$175 million so that we do hope to support a number of the concerns that they have in terms of short-term needs.

Mr. STUPAK. I am sure you saw the article. It has been referred to repeatedly today in the Times-Picayune about hospitals running out of space, they don't have bed space. You have heard that all over the place.

Ms. NORWALK. Absolutely.

Mr. STUPAK. So all those numbers are fine but they don't solve the problem. We need these things resolved. We need them now.

Ms. NORWALK. And if I might add to that, not only do the problems that we have to resolve that issue is far beyond the health care fund. They need housing, they need education, they need to be sure they are safe and secure.

Mr. STUPAK. Absolutely.

Ms. NORWALK. They have population shifts, difference with income, so this is more than just making sure that the health care system dollars are there. It is actually far beyond that so that the staff can come into New Orleans and help support that. And that is really——

Mr. STUPAK. But we need cooperation from everyone, the Federal Government, State, local.

Ms. NORWALK. Absolutely.

Mr. STUPAK. And next time I would appreciate your testimony before 7:00 so our staffs have a chance to go through it.

Ms. NORWALK. No problem.

Mr. STUPAK. And with that, let me turn it over to ranking member, Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman, and I want to thank the panel for being here. Prior to your testimony, we heard the testimony of 13 health care professionals in the area; and every one of them pointed out the many problems that they face, the shortage of primary care providers, a shortage of specialty, a shortage of hospital beds, a shortage of psychiatric help. All of those are problems, and it has been a year-and-a-half since Katrina hit. There have been millions of dollars appropriated and sent to New Orleans and when you hear reasons why we have not done a better job of having an effective health care delivery system in place today, you can—health care is so micromanaged you can always come up with, well, this waiver wasn't given or the poverty level was too high here or poverty level too low here or whatever, whatever, whatever. But Ms. Norwalk, you are very familiar with all these regulations, and Mr. Cerise, you are familiar with all these regulations, so I would just ask the two of you what could be done to expedite this? I mean, I know that each one of you could go on and give 30 minutes of reasons why we haven't done a better job of providing primary care when you consider the money given. But from your perspective, Ms. Norwalk, what is the problem? Why can't we do a better job at this?

Ms. NORWALK. Well, there are a number of different issues. First of all, I would note that particularly Medicare is not really set out to help with disaster relief and recovery. So the first issue that we have when we say, oh, what can we do to help? I think we have done a fair amount to try and help where it is that we can, given that this is a national program.

The second issue is Medicaid. Medicaid is a State-run program where the State is in partnership with the Federal Government, and the Federal Government provides matching funds. But the State has the lead. And the fact of the matter is much as you reference in terms of micromanagement, the Federal Government does not want to do micromanagement of what happens in Louisiana. It is not appropriate. It is their health care system. And that was one of the key principles, and when we first sat down with the State in September and October 2005, that is—not just the State but the entire community, that was really the number one key. So when working with the State and the Collaborative, I think that we have a very good framework to move forward. And there is no doubt that there will continue to be debate about the numbers internally. There always is between the States and CMS whenever you are looking at Medicaid programs. But I think that those are things that we can get beyond in order to make sure that people in Louisiana have insurance or a medical home or stop going to emergency departments to receive care, for example, which helps—which exacerbates the emergency department overcrowding problem that we have. I think there are a lot of things that we can do and are doing with our short-term needs and additional DRA funds to help support getting back recruitment and retention. So getting physicians back, helping with mental health, helping with long-term care, again to get people out of the hospital.

Mr. WHITFIELD. You know, my understanding the insurance is not a problem, having the providers provide care is the problem.

Ms. NORWALK. Well, I think you got—well, that may be the case. I think you may have—you have got a long-term issue. If you want people to come back to New Orleans, physicians and other staff, direct service workers, to come back to New Orleans, they are going to need to know that they have a large patient base and can actually earn a living; and to do that, I suspect that more of them would be interested if they had a wider base, i.e. more insured.

Mr. WHITFIELD. Mr. Cerise, from your perspective, what is frustrating about this for you? What needs to be done?

Dr. CERISE. Well, we have a difference of opinion on how we would attract providers back into the area.

Mr. WHITFIELD. Well, if you have a difference of opinion, who makes the final decision?

Dr. CERISE. Well, we were engaged in a collaborative process. The Collaborative put forth this concept that focused heavily on the delivery system and said that we have lost a lot of capacity. We would like to put the pieces together in a way that is a more coordinated system of care, and we brought that concept in September to CMS and made this case. We have got a lot of capacity needs. If we could put some—a stake in the ground, put a significant capacity, primary care providers, organized in a particular way so that whether they are seeing insured people, uninsured people, they are reimbursed not for episodes of care, not for episodes of illness, but to manage the population, to attract people with chronic disease, to be connected with electronic records, to make a significant impact of a new system of care in a devastated area, create a new model of care delivery. And what—the reaction that we got from Dennis Smith at CMS was essentially go back and bring us back an insurance model that moves DSH dollars to cover people with—to insure the population.

We went back and worked on that. I can tell you, what you heard earlier today was a cry to say can you support, with some certainty, some income for these clinic sites so that we can bring enough capacity back into the region because I don't think as the initial step—we can—it is an interesting debate and we can talk about whether swapping DSH funds for insurance is a smart thing to do long term and cover for more people. But for the immediate impact, I think that swap is not going to make the same impact as funding some delivery sites throughout the city where you have got a huge gap in capacity.

Mr. WHITFIELD. You know, you get the impression just listening to this that there is so much emphasis being placed on the Collaborative and what the health care system in Louisiana is going to look like in the future, that taking steps to get a primary health care system, delivery system into place to take care of the needs today was placed on the back burner. Would you disagree with that?

Dr. CERISE. I think that that is a fair assessment. We have tried to take the approach of while we have a broken system, put the pieces back together in a way that is good for the future, that makes sense for the future. But there is critical capacity that we have to replace today, and I think we have—

Mr. WHITFIELD. It sounds like we need to focus more on just meeting the needs today and then talk about the future later from our perspective. One other question. Dr. Cerise, it is my understanding that nearly \$250 million in DSH monies are currently not being utilized and will expire at the end of the fiscal year if not used. What can and needs to be done to use these funds today?

Dr. CERISE. Well, actually we have less than that available. The States got a DSH cap of a little bit over \$1 billion, and we project that we will spend about—a little bit more than \$950 million or somewhere in that range of DSH. And so the limiting factor on the State drawing down DSH funds for now is State match, putting up 30 cents on the dollar and match to draw that down and having the allowable costs to spend that on. In the prior years we were not at our DSH cap but we are getting very close to our DSH cap right now and certainly there is not \$250 million unspent DSH available this year.

Mr. WHITFIELD. OK. Mr. Chairman, I yield back the balance of my time.

Mr. STUPAK. Ms. DeGette from Colorado for 10 minutes?

Ms. DEGETTE. Thank you, Mr. Chairman. Ms. Norwalk, I want to explore the Secretary's health insurance proposal a little further because I am a little unclear about some of the ideas in the concept. From what I understand, is the general concept of this plan is that you would take DSH monies and rather as happens now in Louisiana where the DSH monies go directly through the charity system, what would happen under this plan is that the DSH monies would be given out to the uninsured to—they would be used to purchase private insurance for those individuals, is that correct?

Ms. NORWALK. That is part of the concept, that is correct.

Ms. DEGETTE. What is the rest of the concept?

Ms. NORWALK. The way that the proposal is structured really is intended to focus on what the State needs are first, and there is no question that the State has raised a concern that there be DSH funds remaining so they continue to have a safety net. So part of that is redirection of some DSH dollars.

Ms. DEGETTE. OK. Is there any sense through the Secretary what percentage of the DSH dollars would be needed to purchase this private insurance for the uninsured individuals and what amount would be reserved for the other individuals?

Ms. NORWALK. It really is up to the State, but it depends on a number of different options. And one of the things we have done is provide the State with a tool to help figure out if you have dialed up or down certain things such as the number of people you want to cover, the poverty level that you cover, the benefit package that is provided and the like.

Ms. DEGETTE. The reason Mr. Stupak was cutting you off and the reason I am cutting you off, and I apologize, and you can certainly supplement your answers in writing is we only have 10 minutes to question the witnesses. So I guess the answer would be that you don't have a firm answer about percentages because it would depend on a lot of variables.

Ms. NORWALK. Correct.

Ms. DEGETTE. Thanks. Now, is this plan similar to the Massachusetts connector plan?

Ms. NORWALK. Again, it is really up to the State in terms of what they want to put together, but there are a number of things that both Massachusetts, California, Indiana, Michigan—a number of States have looked at this type of model. Each plan is different.

Ms. DEGETTE. In fact, Massachusetts plan covers everybody, not just the uninsured.

Ms. NORWALK. Correct.

Ms. DEGETTE. It engages the employers and it engages the insurance company.

Ms. NORWALK. That is correct.

Ms. DEGETTE. So what you are saying is Louisiana could do something like that but you are not giving them the details, you just think—here is a pot of money for DSH. You guys could use it to insure uninsured people.

Ms. NORWALK. One of the concerns they have is to have DSH dollars go to physicians and clinics, for example. Traditionally, DSH does not go to physicians. Disproportionate share hospital payments go to hospitals.

Ms. DEGETTE. Yes, as I said before I am very familiar with DSH.

Ms. NORWALK. Right. I apologize. So appreciating that issue, wanting to be sure if you were going to divert that money in some other way that we can do much as Dr. Cerise has suggested is necessary, and much of the testimony here has been we need to have funds, we need to provide care in an ambulatory setting outside of the hospital. And so this allows the money to follow the person to seek care wherever he or she needs it.

Ms. DEGETTE. Has anybody in HHS done modeling on what this would look like? Have you talked to the insurance companies?

Ms. NORWALK. Yes.

Ms. DEGETTE. Do you have information you can supplement your response? What was their response?

Ms. NORWALK. I think that in fact there are people here today from insurance companies in Louisiana who were very interested in this proposal.

Ms. DEGETTE. OK. So people said they would be interested?

Ms. NORWALK. Yes.

Ms. DEGETTE. And did you get some statistics from them how much this would cost?

Ms. NORWALK. Again, it is going to depend a lot on the benefit package and the poverty level and the like.

Ms. DEGETTE. And you think that should be established by the State?

Ms. NORWALK. Yes, I think it is appropriate for the State.

Ms. DEGETTE. And they would have to then apply for waiver?

Ms. NORWALK. Correct.

Ms. DEGETTE. OK. And so really, the benefits package, the special needs that people had, chronic long-term needs, so something like that, that would all be established in your view by the State and they would come to you with a waiver?

Ms. NORWALK. Correct.

Ms. DEGETTE. And then would it be guaranteed coverage of somebody was uninsured or how would that work?

Ms. NORWALK. Again, that is up to the State to determine whether or not they have guaranteed coverage as I noted earlier. They

may want to keep some DSH funds so that if people aren't uninsured—so for example, I know one of the issues they have is a very large migrant population that might not be covered under State subsidies but may yet be required to be covered in hospital—

Ms. DEGETTE. So it is really for them to decide.

Ms. NORWALK. Correct.

Ms. DEGETTE. So I guess it would be fair to say that this idea about covering the uninsured with DSH funds rather than in the other ways we have discussed is from the Secretary's view more a concept than a plan? Because the plan would have to be developed by the State and then submitted to the Department for waivers, correct?

Ms. NORWALK. Yes, that is correct.

Ms. DEGETTE. OK. Now, Dr. Cerise, what do you think about all that?

Dr. CERISE. The challenge of moving DSH for insurance which I think everyone would love to have everyone in your population insured. If you look at health care spending in Louisiana, in 2004 we spent \$19.4 billion. The focus of much of this conversation is that roughly \$600 million of DSH that is in the public system today, around 3 percent of the health care spending. We have got 18 percent or so uninsured in the State. It is not a simple move of DSH funds to insurance, those DSH funds are buying services today, and if we are going to move that to insurance, we have got to be comfortable that we are insuring the critical mass of the population because if you don't have—when you move them, you are moving them from your safety net, so you do not have those funds to support your safety net. And that is the challenge that we are presented with and in our discussions.

Ms. DEGETTE. And have you been given any information to indicate that you could insure those uninsured individuals with DSH funds while—have you been given any modeling or anything by that by HHS?

Dr. CERISE. We were given a model in January, the tool that Ms. Norwalk referred to, that showed that we could insure 319,000 people using existing DSH funds that were dedicated to the hospitals in the State.

Ms. DEGETTE. OK. And then how many uninsured do you have?

Dr. CERISE. We have somewhere around 700,000 uninsured in the State. That is a number of debate but I think that is a safe number.

Ms. DEGETTE. So you would be covering somewhat less than half of the people?

Dr. CERISE. We feel like the 319,000 is an optimistic projection. I feel comfortable that it would be less than half.

Ms. DEGETTE. And what would happen to the hospitals and other facilities that that DSH money is going to? Would that be all the DSH money?

Dr. CERISE. The remaining DSH funds that we pulled aside earlier in the discussion were for three groups, one, the rural hospitals. Here is about \$85 million that funds care in rural hospitals, the State psychiatric hospitals, which is about \$100 million, and then \$80 million for GME, that actually funds GME. But the re-

mainder of those care dollars would be moved, and so those would not be available for those systems to take care——

Ms. DEGETTE. And the money that would stay, would that be sufficient in the State's view to preserve those programs, those DSH programs?

Dr. CERISE. No.

Ms. DEGETTE. OK. And what would happen to the other 400,000 roughly who didn't get covered with the DSH money?

Dr. CERISE. There would be no organized system of care funded for the remaining uninsured. They could get a hospital-based services. They could show up in the emergency room and hospitals have to take care of those people. They are not funded to take care of them, but they would have to be seen but there would be no coordinated outpatient——

Ms. DEGETTE. There would be no funding for it. Now, what about under that modeling that was given to you by HHS. What would happen about a teaching hospital?

Dr. CERISE. Well, we did carve out the DSH funds for GME and so there are funds that would be either supplanted, if those programs were moved to other hospitals and those costs would end up covered through Medicare or some other mechanism. That is a whole other discussion, but the hospital, for example, LSU Shreveport Hospital relies very heavily on those DSH funds, not only for GME but for service delivery, and they would have real problems.

Ms. DEGETTE. That would be gone. So would it be fair to characterize the State's position to the Secretary's proposal as something that you don't think would be workable for Louisiana?

Dr. CERISE. That is correct. Without substantial additional funds, that swap does not work for us.

Ms. DEGETTE. Do you have any ballpark figure how many additional funds?

Dr. CERISE. I think—we have done a lot of modeling. I would say it is north of a billion dollars.

Ms. DEGETTE. A billion dollars?

Dr. CERISE. A billion for the whole State.

Ms. DEGETTE. That would be per year, right?

Dr. CERISE. Correct.

Ms. DEGETTE. Now, this is why we are having this hearing, so we can bring everyone in.

Ms. NORWALK. The PriceWaterhouseCooper's report says that 40 percent of the uninsured in Louisiana have over 200 percent of the poverty level. So not all the 700,000 would have qualified in any event under the report. Now, I haven't seen the latest statistics from the census bureau that looks at that, but that is the first point I wanted to make. The second point is if you assume that you don't have a medical home system of care and instead are getting treatment in an emergency department or a hospital outpatient department, it absolutely is more expensive.

Ms. DEGETTE. Well, let me just stop you real quick because this 200 percent of poverty level, we were talking to actually a lady from my district last week under our S-CHIP hearings and the problem we have is a lot of uninsured that Dr. Cerise is talking about who will get treated anyway at the emergency rooms are as you say people over 200 percent of poverty level. They are the

working poor, and they cannot afford to buy insurance. So I guess what his point would be that, OK, sure you are going to insure people who are under 200 percent of poverty level through this proposal, but they are still going to be whole bunches of people who don't have insurance, who can't buy insurance out of their pockets, and they are going to be showing up at the doors of these emergency rooms. So where do we pay for that?

Ms. NORWALK. Well, there are a number of things that the State could do, like a sliding scale for example of care. So if they wanted to provide subsidies on a sliding scale, that is one way that they could structure it. Moving care from the hospital outpatient department and the emergency department into a medical home system, which is part of the Collaborative approach, also I think would save a lot of money.

Finally, the concern is from an LSU system, there is at least \$160 million on the table because LSU only has 10 percent of their patients in Medicare, at least traditionally they did before pre-Katrina. There is a lot of Medicare DSH and Medicare GME dollars that aren't being spent because of the patient mix that was at the LSU system pre-Katrina. If they built a new hospital for example, I think their patient mix would change and the number of beds they have for the uninsured in Medicaid would also change, consequently the entire system. Those funds I would imagine would need to move around in any event because of the changing nature of how the system prepares—

Ms. DEGETTE. Well, let me say my time has well expired. I appreciate the comity of the Chair. I think it is urgent that we continue these talks between the State and Federal Government, and I think that the State needs to work on trying to put together some kind of a system and submitting the waivers. But I also think, and the chairman said, he is willing to bring the Secretary in here. I think that the Department needs to look much more broadly because the State doesn't think this is going to work, and I don't think the economies are real great.

So anyway, thank you, Mr. Chairman, for your comity.

Mr. STUPAK. I thank the gentle lady. Mrs. Blackburn, questions?

Mrs. BLACKBURN. Thank you, Mr. Chairman. Dr. Stephens, I want to start with you. I have got this March 3 article from the Times-Picayune which basically says the hold-up that Mr. Smithburg talked about earlier is due to a problem between the city council and the Mayor and getting the approval for these mobile clinics. And it is absolutely beyond me how you can have the situation that you have. You are depending on as Mr. Smithburg put it earlier, the kindness of his brethren at the table to help care for those that are in need of health care and you cannot get this approved.

Now, is the city willing to allow these mobile clinics—they have been there for 7 or 8 months waiting to be used to relieve some of the pressure that is there. Are you willing to see that through to completion immediately?

Dr. STEPHENS. Yes. Thank you. A couple of things, one, the one problem we had is that they were placed in a residential area. A solution would have been to place it in an area that was zoned commercial.

Mrs. BLACKBURN. That is not what I asked. Are you willing to see it through to get a solution immediately? You need it to where people can get to the health care and stubbornness is not going to solve the problem, hesitation is not going to solve the problem. Action is going to solve the problem. Being an outsider looking in, knowing that there is a tremendous amount of money and you were sitting in the room when I listed the money that has been sent, the money that has been spent. How can you not resolve this issue when you have a solution sitting there for 7 or eight 8 and you have chosen not to act on it?

Dr. STEPHENS. First thing, the city council did pass the ordinance to give a waiver so that they can move forward with the project. And No. 2 as I mentioned earlier is that the residential area was a problem and not the commercial area. They had adjacent commercial areas that they could have placed them. And number three, they could have restricted only to kids at the schools, and that could have been open today if it was only to be used by the kids on schools.

Mrs. BLACKBURN. Dr. Stephens, sounds like some excuse-making and I think it would be helpful to see some action on that immediately and not just at some point in the coming months. I think it would be difficult if they sat there for a full year without being utilized and without being used.

Dr. CERISE. I would like to come to you with a couple of questions if I may, please. I want to go back to Dr. Fontenot. I asked her about the permitting and the licensing on these hospitals and what we had found when we were there in New Orleans and some questions that came from that. With your generators and your emergency supplies, being in the basement we found out that there were evacuation plans but there was no implementation plan for those and just—it seemed to be a lot of blame going around and it was Dr. Guidry who had given us that information. What is your association—how do you work with him?

Dr. CERISE. He is in my office. He is a State Health officer.

Mrs. BLACKBURN. OK. Great. Are you still permitting these hospitals—we just heard that switchgear is still in the basement but there is some kind of system of walling them off. You want to—we are coming up on hurricane season soon again. What are you doing to say if we have a difficult situation, how do we get ourselves out of this? So just a couple of seconds on that.

Dr. CERISE. Right. There are two pieces, one is how to mitigate and the other one is with the planning, is to make—if we get in a situation—we have worked very cooperatively with HHS and they have provided a lot of assistance in going to individual facilities, hospitals, nursing facilities to look at who is able to evacuate, how you would evacuate, what the capacity is, what Federal assistance we would need. And so we do have very detailed plans of which each facility's capacity would be.

Second, on the mitigation piece, we have a group that has recently completed its work, extensive surveying, of hospitals and nursing homes to develop building code issues, and that will tie in evacuation plans. If you have certain things in place in certain areas, your plan would be to leave or you would shelter in place.

Mrs. BLACKBURN. Do you have an implementation strategy so that you can move people? This time around, do you have that? Last time around you did not.

Dr. CERISE. Yes, we do.

Mrs. BLACKBURN. You do?

Dr. CERISE. Yes, ma'am.

Mrs. BLACKBURN. Excellent. I want to go to the insurance issue and the 1115 waiver because there is a lot of talk about that, and you all have a State mandate for health care access to all Louisianans, and my question to you on this 1115 waiver, are you looking at Arizona and Tennessee and some of the other States that have had an 1115 waiver and looking at the lessons learned?

Dr. CERISE. We are aware of things that other States have done in order to cover more people, be able to reallocate funds, to not only pick up the full freight but to share costs with employers and individuals. I am not sure if that is what you are referring to.

Mrs. BLACKBURN. I am asking if you are looking at those States, their program, their implementation, their delivery systems and seeing the mistakes that are there and viewing those as lessons learned and asking them for best practices.

Dr. CERISE. We are aware of some of the problems that Tennessee had with the large move to a coverage model from an access model with DSH funds. It is one of the reasons that—honestly, we are being very careful about the assumptions going into this, and the reason we have been hesitant to accept, for instance, a per member per month of \$157 for childless adults as a way to insure people because if those estimates are wrong, the State is going to be on the line for providing that coverage with State funds if we don't get an amendment to the waiver from CMS.

Mrs. BLACKBURN. And you all are already spending just under 30 percent of your State budget on health care, is that not correct?

Dr. CERISE. That is probably about right.

Mrs. BLACKBURN. Are you looking at anything like refundable tax credits or new insurance products or health reimbursement accounts, health savings accounts, thing of that nature to put that into your mix?

Dr. CERISE. The short answer is for this particular initiative, we have looked at the ability to provide an insurance product for people with existing funds. We have not gotten into the details of what that would be.

Mrs. BLACKBURN. OK. And one more quick question. You have gotten \$15 million on the workforce recruitment money, but you think it is going to take \$120 million to rebuild your workforce, is that correct?

Dr. CERISE. That is correct.

Mrs. BLACKBURN. All right. Thank you. I will yield back, Mr. Chairman.

Mr. STUPAK. I thank the gentle lady from Tennessee. Mr. Melancon for 10 minutes questions, please.

Mr. MELANCON. Thank you, Mr. Chairman. Ms. Norwalk, let me ask—maybe this is the dumbest question I am going to ask, but we are 18 months out since the storm's occurrence. Why are we here today? Isn't the Department of Health and Hospitals able to work with the States to try and provide health care to work through the

problems? Why does the Congress have to bring a Department here and all these people from Louisiana here to try and solve what should have been solved by the Agencies themselves.

Ms. NORWALK. We certainly have been working very diligently to make sure that health care is being provided in the area. I think the needs have—the short-term needs, we have continued to work with them. They continue to be exacerbated as populations return, as the populations change. For example, the number of migrant workers that are coming into the area often do not have health insurance and may have workers' comp issues.

Mr. MELANCON. And that is correct because we haven't done a thing. We haven't taken any incremental steps forward. We are worrying about the Charity Hospital and the big building that everybody doesn't want. That is what we are worried about. We are not worried about the teaching facilities for the State of Louisiana, we are not worried about the hospitals in the public sector—private sector going broke, we are not worried about people that we have to give health care to, we are worried about the politics of some building in south Louisiana. The State Collaborative. How many weeks was it between the time—maybe Dr. Cerise—between the time that you all submitted it to the Feds, then they started talking to you again. It was about a 6-week period or was it longer than that?

Dr. CERISE. We submitted it October 20. We had regular discussions for—beginning early November until mid-December, and then there was a 6-week gap before the proposal or the tool was presented to us by CMS.

Mr. MELANCON. Well, if I remember correctly, it was a concept paper for a redesigned health care system for region 1 for a CMS submittal. Prior to a statewide rollout, the State will assess the benefits of the current rural safety net comprised by merely small rural hospitals and the rural health clinics. One of the most important consideration, present implementing the new system of care, its affect on rural communities. Local rural communities face many unique challenges which have not often been addressed in the Collaborative process, as region 1 is primarily an urban area. These challenges include significant shortages of health care professionals. The role of rural hospitals is critical safety-net providers and limited financial resources.

Now, they brought you a rock and then 6 weeks later, after they brought you the rock that you asked them to bring, you tell them that is not the rock you want to take it back and start over again. So where we are now at month 18 is they don't want to continue filling out application forms that you are going to tell them you are not going to accept?

Ms. NORWALK. I actually would characterize it differently. I have a log of all the contacts we had since November say through February, and there were significant conversations long even after they submitted the proposal after October 20.

Mr. MELANCON. Why were you all silent for 6 weeks?

Ms. NORWALK. We weren't silent for 6 weeks. That is my point. We were silent the week of Christmas and for a few days after New Year's. That is true. I apologize. I am sure people were on vacation. So other than that vacation schedule, I have—I can tell you calls

that were made, e-mails that were sent back and forth about financial modeling, about all sorts of issues that relate to this, and we have been——

Mr. MELANCON. Thank you. Dr. Cerise.

Dr. CERISE. We had regular staff calls throughout the month of November and until mid-December. We had no staff calls working through budget neutrality, these technical pieces that we have to work through. CMS cancelled the call the week after my visit to your office, December 12. That next call was cancelled, and the next information I would get on this would be from the Secretary's office, and that is true, I got that. But it was in January and it was the night before a very public release of this tool.

Mr. MELANCON. Was that when we had the——

Dr. CERISE. It was not a discussion point at that point.

Mr. MELANCON. Is that when we had the Irish kilts playing music with your announcement in New Orleans?

Dr. CERISE. No, that was the beginning of the process.

Mr. MELANCON. That was just another pie in the sky. We have heard from the hospitals earlier that they had only gotten a portion of their cost for uncompensated care from the State. What can you tell me about that element of the Collaborative?

Dr. CERISE. The uncompensated care is one piece of the hospitals' problems right now. It is an important piece. But as you have heard, they have got a number of other issues. The DRA provided funds for uncompensated care for a period immediately after the hurricanes. There was about \$134 million allocated for that, about \$100 million of that went to hospitals. For the remainder of that fiscal year—and that was time-limited. It expired at the end of January 2006. Between February and July 2006, the remainder of the State fiscal year, the State appropriated \$52 million in uncompensated care for hospitals in the region. This current fiscal year of 2006, there was \$120 million in uncompensated care appropriated to the hospitals that don't normally get this appropriation but it was in recognition of the fact that the care had shifted from Charity Hospital. \$120 million was a number that we and the Governor decided upon because our calculations thought it would be an amount appropriate to cover the full costs of the uncompensated care in the impacted region. It turns out through discussions with the Hospital Association, they preferred to spread those dollars to other parts of the State as well. There was less available for the New Orleans region, and based on the formula that was put into the Appropriations Act, we don't expect to expend the entire \$120 million. I have been in discussions with some of the hospitals with the division of the administration, looking at how we might go back to do that, but I want to be clear because there has been a lot of discussion about these dollars not flowing. There have been uncompensated care dollars going to—it has been the State's intention—when we discussed this \$120 million with the Hospital Association during the appropriations process, it was our preference to concentrate those dollars in the New Orleans area and cover full what we put forward was 90 percent first dollar uncompensated care costs for all hospitals in the impacted region, which is a different formula.

Nonetheless, when the existing formula that is in the appropriations bill, we expect there will be money left over and are committed to going and looking at how to do that. We just made the first half-year payment on this, and the way this works is you have got to show the cost to be able to get the reimbursement. And based on that first half-year payment, we expect that the entire pool will not be spent.

Mr. MELANCON. Thank you. Where I am right now, and Ms. Norwalk, I know this is just something you have got to do as part of your job today, but I am living this down in south Louisiana. There are other people down there. They are tired. They are frustrated. And if we can't get this government to work for them, then we need to find some people that will. And I am not yelling at you, I am yelling at your Department, please. You know, there has been so much going back and forth, finger-pointing at each other, and nothing getting done. And it started the day after the storm when the Governor of Louisiana was told she didn't ask for the right things from the Federal Government. And it has gone downhill ever since.

I didn't think, and having worked previously in State government and worked with the Federal agencies—usually those people that worked in those departments were there to help guide us and give us assistance and tell us what *I*'s to dot and what *T*'s to cross and how to make it work and not put a stone wall up and try and make us climb over it every time or change the rules every time we came.

So I would ask you to go back to Mr. Leavitt and tell him that this committee is meeting because his agency has not performed the duties and responsibilities they were charged with. And I am going to ask the chairman, you have asked for the records. I would like to have every detailed record, phone calls, e-mails, the whole works. And if we got to spin them, we spin them. If the people of Louisiana are wrong, then we are going to prove them wrong. If the Heath Department is wrong, then we are going to prove them wrong. But I am not going to continue having hearings at infinitum when the people in the Gulf Coast of this country are suffering as they are.

Now, I would like to ask one last question. During the issues with the Collaborative, during the issues with the going back and forth, during your testimony and the drafting of your testimony today, was there any member of our delegation that may have had input or made phone calls on a regular basis, his office or others, about what was going on and what the Department—

Ms. NORWALK. In my testimony?

Mr. MELANCON. No, from your Department from someone in our delegation?

Ms. NORWALK. No one influenced my testimony.

Mr. MELANCON. That is influenced. I asked you if you have had any contacts with people within the Congress that are—

Ms. NORWALK. I personally have not. Whether or not—there may have been contacts within the Department. I really have no idea. But my own testimony was testimony that we wrote, and as far as I know, no one influenced my written or oral testimony in any way, shape, or form that was not within CMS.

Mr. MELANCON. Thank you. I would ask you if you would ask the people that you work with in the Department. Thank you, Mr. Chairman. I yield back.

Mr. STUPAK. Thank you, Mr. Melancon. Dr. Burgess, 10 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. It has been a long day, I have heard a lot of stuff. I will address Mr. Melancon's soliloquy when I get to the end of my questioning. But there are a few things I still want to try to drill down on.

Ms. NORWALK, in HHS, there is a proposed rule CMS 2258-P. It is my understanding the goal of this regulation would be to allow the money to follow the patient. We have heard that several times today that that is a goal that several people have said that they share. And allow the money to be received by the health care provider without having to stop at the State capital. Can you tell us what the status is of this proposal and when it might become effective?

Ms. NORWALK. Well, the rule you are referring to is the rule on certified public expenditures and/or Medicaid. It is currently out of proposed form. The comment period closes next Monday, March 19. It will take us inevitably some time to go through these quite voluminous number of comments we have, particularly from public hospitals and States around the country and other providers that are concerned about this. We will go through those. Once we put out a finalized rule, it will effective 60 days after it is published. I don't know the timing because I would hate to guess—

Mr. BURGESS. OK, so this is not just for Louisiana then?

Ms. NORWALK. That is correct.

Mr. BURGESS. Was there any sort of special rule or special designation because of the Gulf Coast area being so harshly stricken?

Ms. NORWALK. No, we actually have been working with Louisiana on these related issues to DSH funds and certified public expenditures, making sure that the States have access—the public hospitals have access to the funds that they should receive through, say, DSH for example and other governmental transfers.

Mr. BURGESS. Well, Mr. Melancon's concern—forgive me for interrupting but I am going to run out of time and we are going to be kicked out of here. But Mr. Melancon is concerned about the length of time that it takes for money that is generated here to get to where it is needed, and I sympathize with that. I probably have a different perspective than him. I do think that there is a hold up and it may well be the State capital; and if that is the case, can we eliminate that from the chain? Can we just remove that as an obstacle, or is there legislative language that you need from us to remove that obstacle going forward? We are 18 months into this. Heaven help us if we are another 18 months into it and we are still having these same arguments.

Ms. NORWALK. No, the overall issue is in fact a statutory issue, so inasmuch as—because Medicaid is a State-Federal partnership, those funds do flow through the State. I don't believe there is a way that we could change that without statutory change, but we will have to ask our counsels.

Mr. BURGESS. And what about the DSH funds that we have heard so much about today?

Ms. NORWALK. A lot of the DSH funds again flow through the State.

Mr. BURGESS. Can we make that not happen?

Ms. NORWALK. No, I will have to go back to counsel's office but I don't think that we could do that without a statutory change. Not to say that we couldn't change the allocation of how those funds are—but even so, they would run through the State.

Mr. BURGESS. But we have heard from 13 or 14 fine individuals here today who all have good ideas on how to spend the money, and if the problem is that wherever the roadblock is, if we can eliminate one stop to get the money to these fine individuals to get them up and working and get them up and running, I think we should do that.

Dr. CERISE. Let me ask you about the suggestion that Louisiana expand its capability for dealing with uncompensated care. So what do you think can be done on the Federal level to expand the—make those Federal dollars that we generate here, make them more available to the practitioners on the ground?

Dr. CERISE. Well, for the DSH component, it is a State-Federal partnership. There is a State share. The State has to put up its share to draw down the Federal funds and—

Mr. BURGESS. Let me interrupt you then because we heard from Mr. Smithburg. He said when he was in Texas, he could get a provider paid but under his current regime he can't because those DSH funds are prohibited from going to providers as opposed to institutions.

Dr. CERISE. I think what he was referring to was the fact that—two things, one, those funds have to go through a hospital, a hospital that is eligible to receive disproportionate share funds. Those funds then, they can fund clinic activity and—but they have to go through the hospital first. And that hospital is not eligible to get physician cost reimbursed with the—

Mr. BURGESS. All right. Well, what do you need to make that happen? Dr. Quinlan was here and testified for us. What do you need for us to be able to just write the check to Dr. Quinlan?

Dr. CERISE. I probably have a different answer than Leslie. We think it is just interpretation of DSH statute. In fact, we have a—there is a fifth circuit decision in Louisiana dealing with rural hospitals that says that those costs are allowable for physicians, but the Department's position has been that those costs are not allowable for the State.

Mr. BURGESS. Yes, well, we did hear that testimony, that the hospital in the parish next to Jefferson Parish was a critical access hospital and would fit that criteria. I would suggest—there probably is something you can do, either at the State level or at the HHS level and for heaven's sakes, let us get that done so we don't continue to be up here and have to beat each other over the head about this stuff.

Now, Ms. Norwalk, did you have some staff members in Baton Rouge to help with this process that we heard about, the Collaborative process?

Ms. NORWALK. We did have someone there through the end of February and we have had people go down periodically. The Secretary has been down eight times, I have been down, I don't know,

half-a-dozen times, a number of staff people go down a number of times a month in order to help facilitate communications between the State and the Federal Government, as well as dealing with some of the issues that we have seen in other regions. We had someone on the ground full time dealing with health care provider issues. He has since gone back to the regional office of Texas, so it really depends on the timing, but yes, we have had people in Baton Rouge and New Orleans.

Mr. BURGESS. Well, has that full-time staffer, has that been helpful to have that person on the ground?

Ms. NORWALK. I heard many accolades from health care providers who found it very useful to make sure whatever certification issues they might have or other problems they might have in dealing with the Department on a more regular basis could help make sure that we could speed up the access to clinics that were brand new, for example, or whatever—there is one in St. Bernard's parish I believe that we helped facilitate that getting paid as quickly as possible, filling out the forms and any—walking those providers through whatever processes were required so that people could get the care they needed as quickly as possible.

Mr. BURGESS. So are you going to continue that, to keep that staff available?

Ms. NORWALK. Well, they are absolutely available to go back to the region as is necessary.

Mr. BURGESS. It sounds like it is necessary. Dr. Cerise, have you found having a full-time HHS staff there has been helpful?

Dr. CERISE. There have certainly been some issues that they have been able to facilitate, no question about it. The fundamental issues I think here this committee is raising are not the kind, at the level, that would be addressed by the people on the ground.

Mr. BURGESS. I don't know. I would disagree. I would think any help, any help at all, that you could get would be beneficial. Again, we have heard from 13 or 14 wonderful American heroes today and the difficulty they have just doing the most basic parts of their job. And that is troubling to me.

Dr. STEPHENS, before I get too wrapped up in this, let me just ask you, because you made the statement that the New Orleans Health Department will have to rebuild. Now, the responsibility for rebuilding the New Orleans Health Department, is that our responsibility at the Federal level, is that Ms. Norwalk's responsibility, Dr. Cerise's responsibility, Mayor Nagin's responsibility? Whose responsibility is that to rebuild the New Orleans Health Department?

Dr. STEPHENS. I think it is all the above.

Mr. BURGESS. Dr. Stephens, with that, I am running out of time. With all due respect, as you know, if you got too many bosses, no one is in charge. I would submit that you better take responsibility for that. Tell us what you need from us, but please take the leadership on that and get that done. Mrs. Blackburn referenced the primary care trailers that were up and ready to go but required a city ordinance to—that should not be hard. Let us do that. Mr. Melancon waxed eloquently about the failures to the extent that they rest with the Federal agency. I suspect the Federal agency is willing to take responsibility for that. At the same time, they are hardly the only persons involved in this; and my personal opinion,

although I do not have the facts to back it up, but my personal opinion is there is a big logjam at the State level, and I would suggest to this committee that we do everything we can to get those dollars to the hands of the people who are going to provide the care and take care of the sick people in New Orleans, Louisiana, and let that bypass Baton Rouge if it has to happen. I frankly do not understand, yes, we should hold a Federal agency accountable and we should hold DHH accountable, but for the life of me, not one single elected official who has stood for re-election since this hurricane, has been turned out of office. And I find that frankly astounding. It just defies belief with the amount of problems that you have had, yes, I think you need to hold some people accountable and I think those people you need to hold accountable are your elected officials. That is only way something is going to happen, and I really make those comments to the 13 or 14 people who testified earlier because again, I just cannot tell you of the personal pain it has caused me to be unable to get this situation any better than what we find it today.

Thank you, Mr. Chairman. I will yield back.

Mr. STUPAK. Thank you, Mr. Burgess. OK. That just about concludes our hearing today. We have come up with several issues that can—I think believe can be addressed between the State, Federal, and local governments, and I ask you all to go back in the next couple of weeks and try to work on them.

This committee will follow up with each and every one of you to insure that the commitments that are made are going to be kept. As I said earlier, this will be the first of many hearings that we are going to handle, and we want to get back to you for a progress report, and I promise you, we are going to keep the subcommittee moving forward.

Ms. Norwalk, I mentioned to you about the CMS and Dr. Wiltz's application. It is not CMS, it is HRSA.

Ms. NORWALK. Thank you.

Mr. STUPAK. So who is the person in HRSA?

Ms. NORWALK. Betty Duke is the administrator of HRSA.

Mr. STUPAK. Betty Duke?

Ms. NORWALK. I am more than happy to bring that back to her.

Mr. STUPAK. Please do because she will be getting an invite from us to appear before the committee, along with Mr. Dennis Smith on the Collaborative plan. And Dr. Lynch, we still want to hear more about the VA and Big Charity's goal there, so we may ask you to come back. Unfortunately with the limited time and as you can see we are being pushed out of here, so we are going to have to clear here quite quickly. I want to thank each and every one of you for coming.

Mr. Melancon, you had one more thing?

Mr. MELANCON. Ms. Norwalk, I need to apologize to you. I am a little rough today. I don't think it was your department that has the problem with the delegation. Mr. Lynch, would you look into what is going on with the VA LSU statements and let me know if there is anybody that is in there manipulating the statements or trying to manipulate the deal? It is my understanding that the VA is saying now they are going to pull out of the deal with LSU, and I think there is—that might be a basis for another good hearing.

Mr. BURGESS. Mr. Chairman, if I may, I would just say that I would welcome some input from the Louisiana delegation into this process. I think it is necessary.

Mr. MELANCON. Yes, I have been looking for them, too.

Mr. STUPAK. OK. The record is going to be open for 30 days. Mr. Stephens, thank you for moving those trailers. Dr. Cerise, thank you for looking at the nurses. Let us keep moving in a positive direction. We got two down and only 2,000 more to go. Thank you all.

[Whereupon, at 4:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

TESTIMONY OF BRYAN BERTUCCI, M.D.

My name is Dr. Bryan Bertucci. I am a Family Physician and Coroner of St. Bernard Parish. Medicine is not well in St. Bernard. 100 percent of our homes, offices and buildings were destroyed and for the first time in history FEMA declared a parish or county 100 percent destroyed. 154 St. Bernard residents died in Hurricane Katrina.

St. Bernard was flooded twice by Hurricanes Katrina and Rita, experienced an oil spill, liquid mud, mold, snakes, flies, mosquitoes, piles of trash, mice and rats. St. Bernard is a very difficult place to live and despite that our residents continue to return.

Our biggest hindrance is the overwhelming lack of medical facilities. Our 194 bed hospital is gone. Of 150 physicians only 6 remain. Only 10 registered nurses remain. To see certain specialists residents are often required to travel 30–60 miles.

We encountered one financial roadblock after another as we attempted to rebuild. Because Chalmette Medical Center was a fee for service hospital we received no funds. We were penalized for being privatized. Because we were not on the parish budget we received none of the Community Block Grant monies. We were penalized for being independent. The Stafford Act prevented FEMA from assisting with physician and nurses salaries. The parish received \$621 million of Community Block Grant money for infrastructure repairs—medicine received none.

Perhaps our biggest problem is that Federal and often State officials do not realize that St. Bernard Parish is not part of Orleans. Funds given to Orleans Parish stay in Orleans Parish.

Medicine has metamorphosized itself from DMAT teams, to Public Health, to our present 22,000 sq. ft. temporary trailer. We see 100–120 patients a day. The severity of the illnesses in our patients is similar to those seen in a small ER or Urgent care. We I&D abscesses, suture lacerations, stabilize MI and congestive heart failure patients, and give IV fluids and antibiotics. Almost a quarter of these patients have no insurance coverage and are “self pay” or “no pay”.

A foundation is willing to donate 30 acres of land eight feet higher than the land Chalmette Medical Center was located on. We would like to thank the Franciscan Missionaries of Our Lady Health System, Mobile Oil Refinery, and Social Service Block Grant have donated funds but this is not adequate.

Mental Health is in crisis with 50–60 percent of adults and 20–30 percent of children depressed, drug overdoses on the rise, and the chronically ill psychotics and schizophrenics are decompensating due to lack adequate counselors, psychiatrists, and psych beds. Charity Hospital Crisis Intervention Unit destroyed.

St. Bernard lacking significant emergency room services has to ship patients 18–35 miles for emergency care. Our parish is surrounded by water and our limited number of ambulances has to cross bridges, railroad tracks, and circumnavigate traffic jams depending on the time of day. An ambulance ride can vary from 15 minutes to an hour depending on delays encountered. A routine ER wait is 4–8 hours. These patients are occasionally housed in ambulances making vehicles unavailable for hours.

The logical solution for St. Bernard Parish is a medical village consisting of a permanent physician office building, out patient surgery center, and out patient diagnostic center and eventual hospital.

This medical village will assure the resurrection of Primary Care Physicians and subsequent return of our Specialists. It will decrease number of our residents needed to be transferred to hospital ER's as we can treat them locally and free up our Ambulances. It will allow our Elderly to return as Nursing Homes, Homes for Assisted Living are built. Some elderly will rebuild their Homes. It will supply Jobs

as the former hospital was one of the largest employers in the parish. Could provide Psych Beds as our former hospital had 24 psych beds prior to Katrina. With a hospital and medical facilities we can begin work on Electronic Medical Records and Medical Homes.

To make these dreams a reality we need three things.

1. Bridge Money—as soon as possible

A. Social Service Block Grant Money

- we need an extension on funds we were allocated due to expire July, 31–2007
- make more SSBG funds available to medicine in our area for infrastructure.

B. Community Block Grant Funds—since we have a non profit group now, we need to make funds available to build permanent medical structures to replace our present trailer.

C. Rural Designation for St. Bernard—for Medicaid and Medicare patients to help offset costs of treating indigent patients for hospitals and physicians.

2. Medical Village—need money for brick and mortar. Once our out patients facilities are built it will allow access to quality medical care while our hospital is being built.

3 Hospital—the ultimate cure. We have over 25,000 residents. As our elderly return and others receive the ever evasive ROAD Home money to rebuild we will approach the 35,000 we need to support a 40–60 bed hospital. Since it will take 18–24 months to build a hospital we need to begin. Now.

If funds are available I ask that they be earmarked for St. Bernard Village and Hospital Specifically and not to the State or local funding pools as we continue to find them inaccessible.

I have refused to wear a white coat again until medicine in St. Bernard is whole again. To wear a white coat would be like waving a white flag and surrendering to the unacceptable situation that presently exists in medical care.

Thank you for allowing me to voice our Parish dilemma to such a knowledgeable, distinguished, and concerned group. Thank you for listening.

TESTIMONY OF KAREN B. DESALVO, M.D.

Mr. Chairman and members of the subcommittee: Thank you for the opportunity to speak today about post-Hurricane Katrina health care recovery in New Orleans.

I am Dr. Karen DeSalvo, the Executive Director of the Tulane University Community Health Center at Covenant House, a clinic formed in the aftermath of the storm to meet the urgent needs of the population of city. Since September 2005, I have been active in efforts to restore immediate health care services and in planning groups focused on the longer term vision of a redesigned health system.

Before I begin my testimony, I want to thank all the members of the committee for the opportunity to review the progress we have made. Health care is not a partisan topic and many have contributed to our progress, including the city, State and Federal officials you will speak with later. All deserve recognition for working earnestly towards resolution of a uniquely difficult situation for our nation. Your assistance is needed now to help health care recovery efforts in New Orleans continue to progress so that people who are currently uninsured, and without access to essential primary and preventive care receive the care they need.

Today I will share with you my perspective as a primary care physician trying to care for the uninsured patients on our city. I hope to give you a snapshot of what it is like to practice medicine in that environment, the challenges we face, what would help improve access to care in the short run, and how we might go forward to ensure that we provide support for the New Orleans safety-net primary care system while deciding the larger policy issues.

II. PRIMARY CARE RECOVERY: WHAT WE HAVE ACCOMPLISHED

We have come a long way towards restoring health care services in the 18 months since the flood waters receded. Much has been made of the divisions in New Orleans, of our struggles in surviving the storm and its aftermath, and in beginning the process of rebuilding from it. A much overlooked bright spot in those efforts has been the progress we have made as a community in building a care network for our most vulnerable citizens. The community has pulled together in unprecedented ways to overcome overwhelming challenges to restore services and define a better health system.

We described this Louisiana vision for our re-engineered health system through the reports of several planning groups. Health and Human Services provided critical support for much of this work beginning with the United States Public Health Service support of the “Framework for a Healthier New Orleans” and culminating in the Louisiana Health Care Redesign Collaborative Concept Paper (Concept Paper). While we have been planning the future, we have been living in the present, all the while trying to keep within the vision of a distributed ambulatory care system that can make primary care more accessible.

Historically, our safety-net system has been the Charity hospital and associated clinics which were staffed by physicians from both Louisiana State University and Tulane University. An estimated 250,000 people received care, including primary care, through that system. Before the storms, smaller, community-based providers were increasingly working in concert with the Charity system, but their share of safety-net care provision was small.

The flooding caused by Hurricane Katrina destroyed much of the bricks and mortar of the safety-net system in New Orleans and the surrounding area. Affected institutions included the Charity system and all other safety-net providers. Even though we had a successful evacuation of New Orleans, many of the sickest and poorest patients remained behind and needed care. These people were those being pulled out of flood homes where they had been for many days without access to their medications or health care. First responders and others coming to reconstitute our city were also in need of care.

In response to that need, Tulane University resident physicians came to New Orleans in the second week of September 2005 when the waters in most of the city had receded and there were dry places to set up temporary care sites. These physicians-in-training partnered with the police to establish first aid stations and provide general primary care at 6 makeshift sites around town. Most of these clinics were started with meager provisions: a willing physician, a stethoscope, and a few donated, portable supplies. The providers generally worked without power, potable water, or sanitary systems. Some of these health sites were on the sidewalk under tents, some in hotel ballrooms, and others in police station dispatch rooms.

In addition to providing much needed care for patients, these makeshift operations stimulated a culture change in our primary care community. As academic physicians working at Charity, we had provided a major portion of the safety net care for the city through the Charity Hospital based clinics. For those patients who could get an appointment with us, the quality was good. However, we also knew that 12 month waiting periods for new patients to get in to see us, and the lack of sufficient after hours access was preventing us from reaching many.

Creating primary health care from scratch in the post-Katrina environment, gave us first hand experience with a new paradigm of care and an unexpected opportunity to rebuild a better system. Included in this health care culture change was an understanding of the essential role of teams and partnerships, the synergistic value of collaboration, and the benefits a multi-disciplinary approach to care. Also included in this paradigm shift was attention to developing patient-centered models of care. The makeshift clinics were established in response to where the patients were. For example, we identified new sites of care based upon scouting the streets of recently opened zip codes. We then set up our clinics as near to the patients as we could. We worked side-by-side with volunteers from all disciplines. To access care, patients only had to walk up to the card table and ask to be seen.

Over the course of the ensuing weeks, open tent structures were replaced by mobile vans and a few clinics landed space in available buildings such as empty store fronts and dormitories. Eventually, the restoration of utilities moved us back in to these more traditional venues which we generally welcomed. However, we wanted to retain some of the elements of our new paradigm from our “street based” primary care as we moved ahead.

From a care table to a neighborhood-based medical home: Tulane Community Health Center at Covenant House

One of the early temporary care sites opened in early September 2005 when Tulane trainees and faculty set up a card table as temporary care site on the sidewalk in front of the community center. At the height of need, we served 150 patients a day. Desiring to maintain this new neighborhood health clinic, Tulane partnered with Covenant House and Johnson & Johnson to develop a permanent neighborhood clinic nested within a community center (www.tucovenanthealthcenter.org). We had, by default, become a medical home for many in the city, particularly those in the neighborhoods near us and were committed to continuing to that public service.

The Tulane Community Health Center at Covenant House started as a makeshift, post-Katrina first aid station that developed into a permanent primary care clinic. Since transitioning from a card table to a permanent primary care clinic, we have

become a source of primary care for hundreds of patients and have seen over 12,000 since opening our doors 18 months ago. This medical home is able to provide basic primary care for adults including care through a multi-disciplinary health care team. We have access to basic laboratory and diagnostic studies. We also serve as a training site for house staff and medical students and other health professionals so that the next generation of clinicians are exposed to a patient-centric model of primary care. We have a sophisticated electronic health record that allows us to manage our population of patients proactively and provide decision-support for clinicians to improve the quality and cost-effectiveness of care.

We developed a fragile patchwork of referral patterns for laboratory, diagnostic and specialty services. We have a sophisticated electronic health record that allows us to manage our population of patients proactively and provide decision-support for clinicians to improve the cost effectiveness of care.

To support the ongoing delivery of primary care from clinic, we have been aggressively seeking funding so that we can expand our ability to provide health care to this uninsured population. We have strung together our funding from an array of entities including the government, corporations, individual donors, and foreign nations. Specifically, we are supported through the Social Services Block Grant, foundation support from the Avon Foundation, Americares, the American Refugee committee and a generous gift from the People of Qatar.

If we adhere to our budget and expectations, we could provide basic care to 4200 patients at a cost of \$360 per year per person for the next 3 years. In the near future, we are implementing business processes to collect reimbursement from available sources and plan to secure a more stable funding stream. We may request the subcommittee's support as we move forward.

The Partnership for Access to Healthcare (PATH): A Collaborative Prototype for Medical Home System of Care

Though we are focused on meeting the immediate health care needs of the population we serve, we are also working towards creating a neighborhood based-medical home that can not only serve as a potentially replicable model but help to transform the New Orleans health care system. The concept of a medical home has been well described by national groups and our Louisiana Health Care Redesign Collaborative Concept Paper. It emphasizes health promotion, preventive health and primary care, supplemented by peer education and support. The health team is multi-disciplinary and includes social services and mental health support.

Our clinic is one in a newly developed, broader system of care that has emerged since the storm to fill a void left when the traditional safety net was displaced by the flooding. This network of safety net clinics represent service, called the Partnership for Access to Health Care (PATH) (www.pathla.org), represents a broad group of clinics working cooperatively to provide access to care for the uninsured and under-insured. These partnerships bring together public and private entities, academia, consumer groups and corporations into a common goal of filling the need. In the aggregate, these clinics serve 900 patients a day, an estimated 50,000 covered lives. An estimated 90 percent are uninsured and represent the rich racial, ethnic and cultural diversity of post-Katrina New Orleans. Inclusion in the group is open to providers willing to share in the core values of quality and cost-effectiveness. Current participating PATH clinical entities include:

Clinical Providers participating in the Partnership for Access to Healthcare
 Algiers Community Health Clinic (New Orleans Health Department/EXCELth Inc.)
 Common Ground Health Clinic St. Cecilia Clinic (Daughters of Charity Services of New Orleans/EXCELth, Inc.)
 DCSNO at Causeway Clinic (Daughters of Charity Services of New Orleans)
 Jefferson Community Health Centers, Inc Marrero (Jefferson Parish)
 Jefferson Community Health Centers, Inc, Avondale (Jefferson Parish)
 University Hospital (Medical Center of Louisiana at New Orleans)
 Hutchinson Clinic (Medical Center of Louisiana at New Orleans)
 Ida Hymel Health Clinic (New Orleans Health Department/EXCELth, Inc.)
 Edna Pilsbury Health Clinic (New Orleans Health Department)
 Healthcare for the Homeless (New Orleans Health Department)
 McDonough 35 High (New Orleans Health Department)
 St. Charles Community Health Center
 St. Charles Community Health Center (Luling)
 St. Thomas Community Health Center Tulane Community Health Center at Covenant House
 Tulane University Pediatric Clinic and Adolescent Drop in Center at Covenant House

New Orleans Science & Math High (LSU HSC Adolescent School Health Initiative)

Eleanor McCain High (LSU HSC Adolescent School Health Initiative)

These providers have deliberately set out to create a distributed system of neighborhood based clinics that will provide more accessible care for the returning New Orleans population.

These partners have worked collaboratively to identify and fill gaps in primary care services, develop the model of the medical home, and find ways to link their patients into specialty care and other services. With continued support and additional resources, PATH could serve as the core of a future model medical home system of care that could transform medical care in Louisiana. I88III. Primary Care Delivery: The Challenges

The primary care community struggling to provide care for a growing number of uninsured and underinsured individuals faces many challenges. The health system's "short term" needs, which we presumed would be long behind us, continue to dominate our minds, conversations, and energies. The generous support of corporations, foundations and citizens has been a critical bridge, but will be insufficient to rebuild and sustain the primary care safety-net system.

For our part, the major limitations involved poor access to specialty care and diagnostic services. On a daily basis, this means my ability to provide evidence-based care for a typical patient is limited. For example, we do not have access to colon cancer screening and diabetes eye care. We also do not have access to urgent diagnostic studies such as brain imaging or endoscopy. As a result, we sometimes need to rely on sending patients to emergency rooms for such tests. Worse, patients sometimes go without arriving at the hospital with significant or long term health consequences that prevent him from being a productive member of our community.

Like many other clinics in the city, we have an insufficient number of clinical providers at our site. For our part, if we could have more staff, we have the bricks and mortar capacity to expand services and hours. However, as you might imagine, finding physicians and other clinical personnel willing to move to New Orleans is a challenge. There are concerns about long term job security and frustrations about trying to maintain a high standard of practice in a broken environment. One of my physicians has been so frustrated with the difficulties of providing basic care for his patients that he has considered returning to Liberia to practice.

Complicating matters is the high burden of chronic disease for the uninsured, low literacy and the rapidly expanding population of Spanish-speaking immigrants. Adoption of best practices, the use of care management and health information technology will help with the care of those with chronic disease. A strong social services infrastructure can help support those with extensive social service needs. The immigrant population poses its own unique set of challenges for us. The low income workers in this group are likely to not be eligible for coverage if they are undocumented immigrants. We will eventually also need to leverage existing Federal programs to care for these populations.

Congress and the Administration can play a major role in expanding and sustaining access to primary care for our community. We are still in desperate need of additional assistance. Our short term problems are largely not those of bricks and mortar. Instead we are under-resourced and have a short time window until the existing resources we do have will end.

IV. PRIMARY CARE: THE OPPORTUNITIES AND NEEDS

New Orleans and its surrounding region cannot recover without adequate health care services. Sufficient infrastructure and accessibility are essential if we are to retain and attract business and industry, tourism, and have a productive workforce. The most cost-effective means of rebuilding focuses resources on the primary care infrastructure. A robust system of primary care is also critical to unclog an overwhelmed hospital system. If we build a highly functional and accessible system, people will need to use emergency rooms less. Good primary care prevents hospital admissions for illnesses such as asthma, heart failure and diabetes. Patients would be better served prevention, proactive care management and empowering themselves.

We will continue to seek your help in our ongoing efforts to revive the primary care services in the city and region. I understand that Congress faces many issues related to Gulf Coast recovery, and that spending must be done wisely and with an eye toward what will offer the greatest benefit to the most people. Preventing and intervening early in the process of chronic disease saves money. Nothing is more critical to the renewal of New Orleans than health care.

There are three ways that the subcommittee can help us provide immediate access to health care and prevent us from reverting back to relying on emergency rooms for care.

1. Increase access to primary care in New Orleans for the uninsured through extending the SSBG deadline and providing further resources through the Deficit Reduction Act funding

We need to move forward with implementing core components a medical home system of care model that will provide access to care immediately to the nearly 180,000 estimated low income uninsured in our area. The most cost-effective and patient-centered means for doing this is to support and sustain existing primary care resources and add new services to fill gaps until longer term policy decisions can be made.

While our community debates the best way to expand health insurance coverage for our uninsured population, we need to support the continued development of the medical homes and a supportive delivery system of care. This is essential to ensure continued progress rather than returning to a reliance on emergency rooms for care. The PATH network has all the makings of a medical home system of care but it is a fragile system that could dissipate without sufficient support to provide a bridge to the future health system.

Most of these primary care clinics, now medical homes, have been sustained on cobbled together funding from a variety of sources including public funds, such as the Social Services Block Grant (SSBG) funds. On July 31, 2007, the SSBG funding is scheduled to end. For a variety of reasons, there were delays in getting the SSBG funds available to the providers. Fearing that their expenses wouldn't qualify for reimbursement, many clinics have avoided using the SSBG funding instead relying on other resources and on limiting services to their patients. We are now scrambling to spend the money by the deadline for spending all the allocated money. If we do not, the funding will be returned to the Federal Government. Providers in our community have repeatedly requested an extension of the deadline so that we can more effectively use the Federal dollars we've been granted.

An additional option for transitional financial support would be to allocate the discretionary Deficit Reduction Act funds could be used for just such a purpose. It could fund a pilot to assess the impact of a medical home system of care on improving patient health, care quality and lowering overall cost. If successful, we could transfer these best practices to the rest of our State and potentially the nation.

2. Provide financial support for clinicians to help with retention and recruitment

The need for health care professionals and other staff is acute. Staff shortages cause many clinics to turn away patients. Increasingly, recruitment is hampered by care professionals' rational concerns about the long term financial viability of the health care system in New Orleans and the lack of mechanisms to reimburse them for services. To recruit and retain health care professionals, resources are needed that will pay qualified providers for services, support educational loan repayment and defray malpractice costs. HHS and DHH have been working towards this goal, but the allocated resources are not likely to be enough. Additionally, application processes are complex and time consuming. The busy clinicians in this system need streamlined and accessible mechanisms through which they can apply for the financial support. Payment for services rendered could be accomplished through expansion of coverage and though uncompensated care payments directed at physicians.

3. Assist us as we progress and hold us accountable for our commitments

The subcommittee would do this effort a great service by providing assistance and guidance as we move ahead. This hearing has been quite a catalyst for us locally.— We have had better communication and coordination than in months.— All of us have been forced to stop and clearly articulate what would improve access to care immediately.— Such future hearings would help hold us accountable for our promises and allow us to inform the committee members of ongoing success and continuing needs.

VI. CONCLUDING REMARKS

While we work towards agreement on the long term financing structure of our health care system, we need your help right now to ensure access to primary care for our citizens. With the support of the American people and through our public leaders such as those of you on this Sub-committee, we can restore, expand and sustain primary care services to our population—particularly those who are uninsured.

New Orleans survived the hurricanes and the subsequent flood. But survival, alone, is not the goal of our citizens and is not a suitable objective for the nation. To thrive, to be anything close to the city that it was, New Orleans needs a health care system that all of its citizens can rely upon. The storm has given us a great

opportunity to demonstrate the health system of the future—one built around the needs of patients, one readily accessible to all citizens and one that promotes health rather than simply treating illness.
Thank you.



SCHOOL OF MEDICINE

*Department of Medicine
Section of General Internal Medicine and Geriatrics*

March 19, 2007

The Honorable John Dingell
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Dingell:

This letter is written to express my gratitude for allowing us the opportunity to provide testimony before the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations on March 13, 2007. Your attention to and concern for the critical health care situation in the New Orleans region eighteen months after Hurricane Katrina is most welcomed and reassuring.

As you heard recurrently from the testimony of the front-line providers, we need your help right now to ensure access to primary care for our citizens while we work towards agreement on the long term health policy issues. Specific measures that will be helpful in the short-term include:

1. Increase access to primary care in New Orleans for the uninsured through extending the SSBG deadline and providing bridging resources to the safety-net clinics through remaining Deficit Reduction Act funding

a. Most of these primary care clinics, now medical homes, have been sustained on cobbled together funding from a variety of sources including public funds, such as the Social Services Block Grant (SSBG) funds. On July 31, 2007, the SSBG funding is scheduled to end. For a variety of reasons, there were delays in getting the SSBG funds available to the providers. Fearing that their expenses wouldn't qualify for reimbursement, many clinics have avoided using the SSBG funding instead relying on other resources and on limiting services to their patients. We are now scrambling to spend the money by the deadline for spending all the allocated money. If we do not, the funding will be returned to the federal government. Providers in our community have repeatedly requested an extension of the deadline so that we can more effectively use the federal dollars we've been granted.

b. Please also consider encouraging the United States Secretary of Health and Human Services, Michael O. Leavitt to use discretionary Deficit Reduction Act funds to provide

transitional financial support to fund a pilot to assess the impact of a medical home system of care on improving patient health, care quality and lowering overall cost. If successful, we could transfer these best practices to the rest of our state and potentially the nation. It will also prevent slippage backwards into less efficient and effective forms of care.

2. Provide financial support for clinicians to help with retention and recruitment of primary care and specialty physicians

a. To recruit and retain health care professionals, resources are needed that will pay qualified providers for services, support educational loan repayment and defray malpractice costs. HHS and DHH have been working towards this goal, but the allocated resources are not likely to be enough. Additionally, application processes are complex and time consuming. The busy clinicians in this system need streamlined and accessible mechanisms through which they can apply for the financial support.

b. Payment for services rendered could be accomplished through expansion of coverage and though uncompensated care payments directed at physicians.

We look forward to working with you to ensure that these hearings result in action that will help us provide immediate access to health care for our most vulnerable citizens and move forward from our present support progressive improvements in our health care system that will truly serve the citizens of our region.

Thank you once again. We have many challenges to overcome that with the support of the American people and leaders such as yourself, we will recover.

Regards,



Karen B. DeSalvo, MD, MPH, MSc

Cc: Chris Knauer
Peter Spencer

TESTIMONY OF DONALD T. ERWIN, M.D.

I. INTRODUCTION

I would like to thank the chairman and the members of the committee for their interest in the health of our citizens, and for holding these hearings. Your commitment to understanding how we might all work to improve their care is appreciated.

ST. THOMAS COMMUNITY CLINIC PRE KATRINA

The St. Thomas Clinic was established in 1987 by a partnership between the residents of one of New Orleans's largest public housing developments (St. Thomas Housing Development), and concerned leaders in the medical and faith-based communities. The citizens of this neighborhood wanted accessible primary and preventive care within a reasonable distance of their home, with reasonable wait times, and continuity of their care with the same doctor or group of providers. The elected leadership of the predominately African American housing development also insisted that both the clinic board, and its providers, understand the dynamics of institutionalized racism and its impact on healthcare for people of color.

Over the last 20 years this clinic has provided low cost, efficient care to the uninsured and underinsured through public/private sources of funding. I was one of the founders of the St. Thomas Clinic and served as president of the board for 16 years. I was also Chairman of the Department of Medicine at Ochsner Clinic Foundation much of that time. Ochsner leadership was very supportive of the relationship with St. Thomas. Providing appropriate primary, preventive and basic specialty care to outpatients helped minimize hospitalizations and emergency room visits. St. Thomas Clinic has been an important site for the training of Medical Students, Internal Medicine Residents, Family Practice Residents, Nurse Practitioners, and Doctor of Pharmacy students from LSU, Ochsner, Xavier and Tulane. It has been an attractive training site because of its position in a vibrant community setting and its commitment to try to reduce health disparities. In addition to Ochsner, St. Thomas has had innovative partnerships with private providers such as the EENT Foundation, Touro Infirmary Hospital and the former Mercy Hospital in New Orleans. These private providers all recognized the value of the relationship with a community based clinic trying to address the needs of a large uninsured population. We all learned that the collaborations of these public and private entities provided high quality, lower cost care to the community, while at the same time reducing emergency room visits and hospitalization rates that burden the rest of the healthcare delivery system. While receiving grants from State, city and Federal programs, St. Thomas has remained independent, not for profit, and is not under the governance of the State or Federal healthcare clinic systems.

ST. THOMAS COMMUNITY HEALTH CENTER POST KATRINA

My physician wife, who had been medical director at St. Thomas for 12 years and is now on faculty of the LSU School of Public Health, returned with me to New Orleans in mid-September after the Hurricane of August 2005. We attended some of the initial planning meetings for the re-establishment of health services as the city repopulated. I was soon approached by faculty and residents from LSU School of Medicine who were concerned about patients they had treated pre-Katrina at the Medical Center of Louisiana at New Orleans (MCLNO), and in many instances they had continued to see while the patients were in emergency shelters around the State. Many of these patients, who had evacuated to safer sites, were now returning to New Orleans and had little access to medical care. Having begun and operated St. Thomas Clinic before, we were able to relatively quickly re-open as the St. Thomas Community Health Center and find supporters who were already familiar with the clinic and the community. Neighbors immediately appeared with brooms and mops to help with the clean up. The Baldwin County Baptist Builders, from Baldwin County, Alabama, were onsite within days to begin repairing the roof and rebuilding the flooring of the clinic. Building supplies were extremely scarce, so the AmeriCares Corporation loaded a tractor trailer with building supplies in Connecticut and had them at St. Thomas when the Baptists Builders arrived. For clinical services, it was necessary to begin anew. Along with clinics such as Covenant House, we were one of the first primary care clinics to open in the city. We are, and always have been, open to all patients regardless of ability to pay.

We have found that the patient population at St. Thomas has changed since Katrina. The clinic's current patients include those patients living in a cycle of poverty that St. Thomas has traditionally cared for, but the clinic now has a large population of patients who, prior to Katrina, had health insurance, but lost it when their

employer's business failed. A third population of patients is those now coming to St. Thomas because they have lost their local physician. At least 50 percent of the physicians practicing in New Orleans pre-Katrina have not returned. This group of patients who lost their physicians includes some who have insurance and/or the ability to pay all, or part of, their bill, calculated on a sliding scale which is based on Federal poverty guidelines. We now find that 25 percent of St. Thomas patients can pay for some or all of their care. Even for those with health insurance in our community, there are simply not enough physicians to take care of the patients. While the presence of insured patients helps St. Thomas be somewhat self sufficient, it also strains our resources. But the message is clear that the health issues in New Orleans are not just about the indigent or the uninsured.

Partly because of our history in the community, and partly because of the dire straits of the city, St. Thomas has received very generous support from agencies and partners who have joined with us. Since Katrina, we have received over \$1.4 million in grants and contributions, having come from more than 30 separate sources since the storm. Contributions have ranged from \$200 to \$500,000. Due to the chaos in our environment, we do not know precisely how many patients we saw in the first 2-3 months that we were open, but we do know that in the last 15 months we have had approximately 23,000 patient visits. We average 70-80 patients per day in primary care, with another 30 patients seen who come for breast and pelvic exams including mammography, and another 20 patients seen for eye exams and treatment in Optometry. Thus, in the relatively limited space of 5500 square feet, we are providing care for approximately 120 patients per day.

Any provider working in New Orleans can attest to the fact that there are few "brief" patient visits. The patients have virtually all sustained losses, in many cases almost unimaginable, and providing adequate care involves understanding how the patient can manage their medical condition within their current life circumstances.

It is impossible not to be impressed with the resiliency of the people and their determination to put their lives back together. Most of the patients deal with their stress by themselves. However, many simply cannot, and we hope to provide help in other ways, specifically through opening a community mental health program in space we have just leased.

The list of donors to St. Thomas since Katrina is impressive. But more important, to us, was the way we were able to leverage their donations by having donors collaborate with other donors to help us. We found donors interested in common issues and were able to combine donations in a complementary fashion for greater effect. Some of these are described below.

Like other safety net providers left standing after Katrina, we at St. Thomas realized we were now being called on to fill huge gaps in the delivery of service. These were daunting problems, but we often found support from unexpected sources. The clinic's earliest support came from faith based institutions, but we also had significant support from public, private, State and Federal sources that we could not have anticipated.

While the media frequently reports of what is wrong in New Orleans, there have been some remarkable collaborations and partnerships that helped us continue serving our community. The clinic has been blessed with resources and has tried to be a good steward of them. Many of our collaborative efforts did not exist before Katrina. These safety net partnerships and collaborative efforts provided such positive results, that we feel they should be maintained the future health care design.

The following are some brief descriptions of a few of the ways that donations of time and support have been leveraged by complementary collaborations between St. Thomas and its donor partners.

(1) REPAIRING STORM DAMAGE TO THE BUILDING

Immediately after the storm, neither construction workers nor building supplies were available locally. We asked friends from the Baldwin County Alabama Baptist Builders to plan with the AmeriCares Corporation in Connecticut, and the result was the timely arrival of both building supplies and construction crews within days of our asking for their help. They were able to make the necessary repairs so the clinic could re-open. The cost for these repairs, if we could have found someone to do them, would have been in excess of \$100,000. It is just one example of the self-sufficiency that St. Thomas and our sister clinics showed in getting into service quickly.

(2) RESUMPTION OF CLINIC MEDICAL OPERATIONS

The National Episcopal Church and the Louisiana Diocese of the Episcopal Church soon after Katrina declared themselves to be partners with St. Thomas. The

church repeatedly worked with us over the last 18 months to arrange to hire providers and persuade other donors to partner with us. The church provided St. Thomas the initial funds to pay LSU School of Medicine for our initial medical staff and resident trainees. As we set about to hire permanent staff, the church provided bridge financing to assure the salaries of 3 full time physicians who are also jointly on the faculty of LSU Medical School. When St. Thomas was offered the unique opportunity to provide cardiology specialty consultations in the clinic, the Diocese agreed to underwrite the necessary renovations of the space for cardiology as we sought other grants. Most recently, the clinic has been able to lease space to begin a community mental health center. Once again, the Episcopal Diocese of Louisiana recruited benefactors from out of State to agree to underwrite the building renovations and hiring of staff.

In great part due to the promise of secure funding by the church, St. Thomas now has three full time adult primary care providers, all of whom are jointly on the faculty of the LSU School of Medicine and /or the LSU School of Public Health. We have a full time pediatrician who joined us from the community. We have 5 part time specialty care providers. Specialty services St. Thomas offers now include cardiology (see below), gynecology (by a community gynecologist), pulmonology and rheumatology (from their respective departments at LSU School of Medicine), optometry, (funded by the EENT foundation), and nephrology (from a volunteer working at another State medical facility). Each of the rheumatology, pulmonology and nephrology specialty providers, while very beneficial in reducing emergency room visits and avoiding hospitalization of our patients, costs St. Thomas approximately \$25,000 annually and visit the clinic one half day per week.

3) Breast and Cervical Disease Prevention and Management:

The LSU School of Public Health recognized that St. Thomas could provide the site for them to maintain operations of their Louisiana Breast and Cervical Health program, which is sponsored by the Centers for Disease Control and Prevention. Recognizing this possibility, the School of Public Health helped St. Thomas develop a consortium of funders that includes the Avon Corporation, Komen Foundation, and the United Way. This collaboration provided over \$530,000 to St. Thomas. The medical outcome of this collaboration is that St. Thomas Community Health Center is the only site in the city where uninsured women can receive breast cancer screening complete with both screening and diagnostic mammography, breast biopsies, and follow up care arranged with providers who will care for our breast cancer patients for the Medicaid rate we can provide.

(4) SPECIALIZED CARDIOLOGY CONSULTATIONS AND CARE

One of the most remarkable and unexpected collaborations has resulted in St. Thomas being able to offer cardiac consultative tests and specialized patient management. At the suggestion of Dr Keith C Ferdinand, a nationally recognized New Orleans cardiologist, The Association of Black Cardiologists (ABC) approached the Morehouse School of Medicine on behalf of St. Thomas to provide cardiac care to the community. The ABC knew of St. Thomas from the clinic's previous work dealing with health care disparities. Cardiac care was an urgent issue for our uninsured community, as patients requiring elective cardiac evaluations and diagnostic testing had to travel either 60 or 80 miles away to one of the open Charity Hospitals. Spearheading the effort, the ABC and the Morehouse School of Medicine helped develop a group of providers, manufacturers and professional organizations who all agreed to help St. Thomas meet the need for cardiac care in the uninsured community. This collaboration now includes not only ABC and Morehouse, but also professional groups including the National Board of the American College of Cardiology, the Louisiana Chapter of the American College of Cardiology, the Ochsner Clinic Foundation Department of Cardiology, the New Orleans Medical Foundation, and corporations such as Astra Zeneca, Cardiac Science, and the Toshiba Corporation. Providing direct care to St. Thomas, a community cardiologist (Dr Gary Sander), and Ochsner Clinic Foundation Cardiologists come to St. Thomas 2 half-days a week to see our patients and supervise testing. This diagnostic testing now includes standard EKGs, echocardiograms, 24 hour Holter monitoring and interpretation, and most recently, stress echocardiography. We are currently negotiating for hospital support when Invasive catheterization and surgery is necessary. Our physicians are certain that having these diagnostic and management services available in the clinic, especially having cardiologists help with the management of complex patients, has resulted in a reduction of both hospitalizations, and visits to the emergency room for our patients with heart disease.

The volume of patients who are seen in cardiology or any of the other specialty areas at St. Thomas, are not just from St Thomas Clinic alone. We have invited all

of our sister clinics, i.e. Daughters of Charity, Common Ground, St Charles CHC, and Covenant House, to use these any of these specialty consultations.

We are very pleased that the Medical Center of Louisiana at University Hospital is now open and also providing cardiac specialty care. This is a great step forward for our community. We hope to continue to partner with, and augment State and local efforts, and the community is hopeful additional beds will soon open for interventional cardiac care for the uninsured.

(5) ENHANCED SYSTEMS DEVELOPMENT

The Partners for Access to Health Care, (PATH) a subsidiary of the Louisiana Public Health Institute has provided hardware, software and licensing support for an Electronic Medical Record for the St.Thomas clinic. Once this became available, both public and a private support came to St.Thomas to maximize our systems of registration, billing, coding and collection. Blue Cross Blue Shield Foundation of Louisiana is able to provide sophisticated business support and personnel, and they are joining with one of our sister clinics, the Saint Charles Community Health Center to assist in applying this expertise to the every day operations at St.Thomas. As we become more efficient with our different systems, we feel we can increase the number of patients seen significantly, thus not only increasing the number of patients seen, but also reducing the cost of care per patient borne by St. Thomas .

(6) Another partnership that has been made available to us is an alliance with the Eye Ear Nose and Throat Foundation. This foundation provides support for St.Thomas patients with Eye or Ear Nose and Throat disease. These patients can be seen in the private sector once they have been screened by St.Thomas. This has been crucial to protect the vision of our diabetic patients at risk for serious diabetic eye diseases. Several local hospitals, and private Eye, Ear, Nose and Throat physicians, have agreed to see our patients for the Medicare rate fees the EENT Foundation provides. This has been especially important since the public hospital ENT programs are still located in Baton Rouge and will be for the foreseeable future.

(7) Another very important ally has been the Bush Clinton Katrina Fund, which gave us our largest donation to date, \$500,000. While critically important, like so many of our grants, this is a one time only grant, and must be spent within one year of receipt.

(8) The last source of support to highlight is the Social Service Block Grant, which was made available by the Federal Government to safety net clinics. As these funds were being negotiated and the grant programs developed, the Louisiana State Department of Health and Hospitals, led by Dr Fred Cerise and Ms Kristi Nichols, aggressively fought for funds for safety net providers like St.Thomas and sped up the negotiations necessary to get the funds to these providers. St.Thomas received an SSBG grant of \$755,000 in the second year of our post Katrina operations. The estimated operating deficit of the clinic for that year was \$800,000, demonstrating how critical the timely distribution of those funds was for St.Thomas. Like the Bush Clinton Katrina Relief Fund, our gratitude for this funding is great. Nonetheless, one time grants highlight our need to identify and secure stable funding to sustain operations.

In addition to the above contributions, we have received generous support from other charitable and relief organizations, including the National Association of Free Clinics, Robert Wood Johnson Foundation, Operation USA, Direct Relief International, individual Presbyterian churches and Episcopal parishes, the Acadiana Foundation, the Area Health Education Foundation, and individual, sometimes anonymous, donors.

One of the important reasons for the collaborations among these clinics is that enhanced primary care is clearly the best way to provide convenient, high quality care with provider continuity. This is important to patients, but it is also the most effective way to reduce emergency room visits and hospitalizations. The community clinics that make up the PATH organization all want to continue to have linkage to the academic specialty services at Medical Center of New Orleans, and we are pleased to see how effectively Dr. Dwayne Thomas, Dr. Cathi Fontenot and other members of the management of University Hospital at the Medical Center of Louisiana have been at getting the hospital open and specialty services brought back. But in spite of their effectiveness, there are still limited beds in the University Hospital that are just not yet resolved.

There exists within the PATH organization a sub group of 5 clinics that are similar in that they are all independent, not-for-profit, clinics. None are part of the City of New Orleans Clinics, or the Medical Center of Louisiana at New Orleans. The critical services provided by these clinics have become more important since Katrina, but they have no guaranteed recurrent funding. They include St.Thomas

Community Health Center, St. Charles Community Health Center, Common Ground Clinic, Covenant House Clinic, and Daughters of Charity Health Center. We share common goals, and try to support each other, and have learned the value of sharing resources, even if limited. Thus, St. Thomas Clinic shares all the specialty services we have listed above with each of these five clinics, and each of them, in turn, has provided varied useful resources to St. Thomas. We are currently seeking shared support based on the premise that funders might well be more receptive to helping us in order to support the development of a network to improve our efficiency and effectiveness as we maximize our community support services.

CONCLUSION

The funding for St. Thomas Community Health Center has been substantial but it is a patchwork of organizations that have been generous to us. It has taken resourcefulness, prayer, and extensive community relationships to develop support from more than 30 partners who help St. Thomas provide the level of service it provides. Many of the grants to the clinic have been related to Katrina, and are one time only events. While appreciative of the generosity of our partners, the quest for ongoing funding is constant.

As we consider funding the future of St. Thomas, a major issue is timing. Most experts agree that even if, as we hope, the Medical Center of Louisiana at New Orleans can be rebuilt in a way that adequately addresses the need for primary care, prevention, specialty care and hospitalization for the uninsured, at the earliest, the process will take years. The St. Thomas Clinic was begun by citizens asking for community based, accessible and patient centered care. The clinic provided that over the years and now, thanks to generous funding, is doing it on a larger scale and is also meeting some of the specialty care needs that is currently limited or non-existent at the State hospital. It is likely that the services we provide will be needed for the foreseeable future as the health care system is being rebuilt. The St. Thomas Community Health Center, and others like it, arose from a need before and after Katrina to address issues of healthcare for the uninsured in New Orleans. We would ask that Congress consider assisting these clinics to continue to provide these services with gap funding, and to provide consultative support to help us structure a sustainable clinic network.

Whether they be called medical homes or community based clinics, we feel that clinics like St. Thomas and our sister clinics in PATH organization provide important resources for health care in the future. We provide not only compassionate, skilled, and readily available care, but we have also learned how to develop our collaborative efforts to leverage the care that any and all of us are able to provide independently. What we need is on site assistance in formal network development, and strategic suggestions on building sustainable funding.

There is considerable debate at present about the specific health care program that should be developed for the future of the State of Louisiana. I would not want anyone to construe my testimony before you, to be an endorsement of one group over the other, private versus public. I can honestly say that after 30 years in on part or another of the health system in New Orleans, I have been very heartened at the energy and determination of my colleagues at Charity Hospital (MCLNO), the commitment and sincerity of the leaders of the State Department of Health and Hospitals, and also physicians in the private sector, all of whom are trying to address this overwhelming challenge of providing basic healthcare to the uninsured and underinsured members of our community. We appreciate the importance of the patient having choice in any health care system. We also appreciate the quality and care benefits that come from a medical home in which one can find both primary care and access to specialty services and hospitalization when necessary. We want to continue to develop efficiencies and the other components of a true medical home. We feel this is the best way to provide comprehensive primary care to the community.

Our experience at St. Thomas is that this community desires respectful and readily accessible access to care. They want, and deserve, timely evaluation and treatment for diseases found in the primary care setting. All our citizens deserve to have the opportunity to prevent chronic diseases and to detect problems such as coronary heart disease and cancer before they cause lifelong disability or death. We know that timely, appropriate specialty care in the outpatient setting is an integral part of comprehensive care. Management of patients by the collaboration of primary care providers, and specialists when appropriate, provides the most cost effective, highest quality care while it simultaneously lowers emergency room visits and hospitalizations.

What we have done over the years at St. Thomas, and particularly since Hurricane Katrina, has been to try, on a small scale, to provide both primary and preventive care, with specialty consultations as possible. The opportunities, collaboration, and generosity of the American people following Katrina has allowed St. Thomas to do more than ever before.

The St. Thomas Community Health Center, and our group of health clinics that have shouldered the majority of care for the last 18 months, now seek the help of this committee to be able to continue these services while fully supporting the restoration of services at MCLNO. We also urge that clinics with proven track records in the community such as ours be considered to be integral parts of whatever plans are ultimately developed for the long term.

Our current mission:

- (1) To continue to provide primary care to all patients, regardless of their ability to pay.
- (2) To provide services to those who, in spite of their ability to pay, cannot find a physician.
- (3) To continue to develop outpatient specialty consultative services and to make them available to other primary care providers, to improve outcomes and reduce reliance on the emergency rooms and hospitals.
- (4) To develop and provide a community based mental health center, focusing on youth, and families, who are dealing with the continuing stress related to the loss of their community caused by Katrina.
- (5) And most important, to develop the appropriate networking infrastructure and efficiencies to enhance and sustain the services we deliver.

Our most pressing needs for the immediate future include:

- (1) Stable, dependable, gap funding until the new self-sustaining health care model is in place.
- (2) Available specialty consultations for complicated patients, (for the management of cancer, gastro-intestinal diseases and other complex conditions, and surgical specialty care such as urology, and orthopedics).
- (3) Mental health providers, including inpatient mental health beds and ongoing outpatient mental health services.
- (4) Improving our systems support to maximize the numbers of patients we can effectively and appropriately see.

I would once again thank the chairman and the members of the committee for the opportunity to participate in this hearing.

[Dr. Erwin's answers to submitted questions from Mr. Whitfield follow:]

Dr. Erwin

April 27, 2007

Honorable Ed Whitfield,

1. What, in your view, is needed to expand Federally Qualified Health Centers in the New Orleans region, especially Orleans Parish? Please describe any impediments that you would anticipate at the federal, state and local level if you were to seek federally qualified status for St Thomas Community Health Center.

Thank you for asking questions relative to our organization, the St. Thomas Community Health Center and how we might achieve Federally Qualified Health Center (FQHC) status.

Louisiana, compared to its neighbors in Mississippi, Texas, and Arkansas, has a disproportionately low number of FQHCs, especially in light of the high percentage of low-income population, health disparities, and unsatisfactory health care indicators that continue to exist.

St Thomas Community Health Center has not applied for FQHC status since Hurricane Katrina. However, my experience with the application and approval process goes back to 1995 when we initially considered applying for FQHC status. The process has been the same regarding new application for FQHC status since that time.

Representatives of the Health Resources and Services Administration (HRSA), were in New Orleans, and presented grant awards to three FQHC network organizations this past week. As you are aware, HRSA's responsibilities include all of the following: a) U.S. Public Health Service (PHS) section 330 New Access Point (NAP) grant applications for new sites (core), and also b) satellite sites (expansion of existing FQHCs), as well as c) as well as approving FQHC Look-Alike status, and also d) Scope of Project Policy Change applications. For FY 2007, 280 New Access Point grant applications were submitted to HRSA, which is expected to yield 102 (36%) new sites.

We applaud HRSA for their efforts in awarding more 330 federal funding into our severely medically underserved area. The grant awards to organizations in the New Orleans area included three New Orleans metropolitan area grants awarded to two existing FQHC organizations, 1) Two to EXCELth, Inc. (Algiers and Gentilly) in New Orleans, and 2) one to the Jefferson Community Health Care Centers (Marrero) in Jefferson Parish. No new organizations were awarded FQHC status, even though primary care capacity in this market has not been achieved.

The intention of the President's Health Centers Initiative regarding increasing primary health care access in 1,200 of the neediest counties across the nation is for both new FQHC sites (new sites to HRSA) as well as to existing, established FQHC sites to be considered.

The process for applying for a new FQHC includes completion of the application form after considerable, usually consultative, assistance to understand the nature of the process. Understanding the nature of the application, the application process and style of the written grant are all important. After submission, a "technical review" is performed by the federal agency and a score assigned to the application. Additional documentation

is usually required and submitted at this point. Following this there is an “objective review” wherein an outside reviewer is sought by HRSA.

Part of the application seeks to know who is providing care to the population in question at present. The process asks if the applicant has the support of the existing FQHCs in the community. Specifically, the new applicant is asked to show it has the support of the other FQHCs in the community, and how this new FQHC would fit strategically. An accepted policy is that a new applicant does not necessarily need the support of the existing FQHCs, but if it does not have that support, it will be necessary to show why the applicant was unable to get that support of the existing FQHCs. After satisfactory completion of the process, including achieving the requisite community and political support, new applicants are then compared competitively with applications from across the country.

EXCELth, Inc. is the only section 330(e) federally funded FQHC organization in Orleans Parish. According to their Executive Director, Mr. Michael Andry, EXCELth was awarded its first grant in April, 1995. EXCELth has one city clinic (Algiers) and 2 affiliated Daughters of Charity clinic sites. The only other FQHCs ever granted in New Orleans were: one to the City of New Orleans Health Department for health care to the homeless, and one to the New Orleans Health Corporation, which no longer has FQHC status. The adjacent Jefferson Parish has never had more than one FQHC grantee.

I believe that it is very appropriate to consider St Thomas Community Health Center for FQHC status as we are now a health center with over 10,000 unduplicated, medically underserved user patients and have a built-in “users presence.” Thus far, the only option for St Thomas to become an FQHC grantee has been through becoming part of the EXCELth network. St Thomas has had a well defined community presence, and has been governed by a community directed board since the early 1990s.

We at St Thomas Community Health Center have been reluctant to join the EXCELth network because doing so requires us to be governed by the EXCELth board and by its governing policies and procedures. We are reluctant to give up our autonomy, and especially reluctant to give up our community defined, and consumer dominated, board of directors. Our advocacy for the St Thomas/Irish Channel community’s well defined goals for health and wellness would be diminished if we remove this African American community’s members of our board. For many years, St Thomas Community Health Center has been part of a coalition of agencies who serve the St Thomas /Irish Channel community, and who are responsive to the defined African American community leadership. We have especially been strong advocates of the community’s initiatives concerning health care disparities, and particularly, we have been committed to working with the community developing policies that reflect the belief that race is an independent health risk variable.

We at St. Thomas Community Health Center are well established in the City of New Orleans Planning District No. 2 community, and as such, do not feel we represent any competition to EXCELth network regarding the provision of services to patients in our local community. There is no FQHC service site located in the neighborhoods referred to as St. Thomas/Irish Channel or in City of New Orleans Planning District No. 2 and capacity within Orleans Parish has not been achieved. There was one FQHC organization with only one site in all Jefferson Parish (East Jefferson Community Health Center) and that organization lost its 330 grant funding. Another grantee, Jefferson

Community Health Centers has taken its place since that time. The pre-Katrina population of the New Orleans metropolitan area totaled slightly more than 1 million persons and with repopulation since the storm, is about 70 percent of that figure. EXCELth, Inc. and Jefferson Community Health Centers, along with a satellite site of St. Charles Community Health Center (SCCHC) in Kenner (Jefferson Parish), are the only FQHC networks in all Region I constituting the following parishes: Orleans, Jefferson, St. Bernard, and Plaquemines.

In the City of New Orleans Primary Care Strategic Plan (May 2005) that was April 27, 2007 commissioned by the New Orleans Department of Health, Critical Issue 1 highlighted the high poverty rate in the city and the fact that Orleans Parish ranked 61st out of Louisiana's 64 parishes relative to percent of its residents living in poverty. Further, Louisiana has the 3rd highest rate of uninsured residents in the nation. In the "Plan's" findings, it was indicated that 62.0 percent of New Orleans Planning District 2, which includes St. Thomas/Irish Channel, have income \leq 200 percent of poverty. This is the community St Thomas Community Health Center has served since 1987 without regard to ability of the patient to pay.

The major health care needs of the predominantly African American St. Thomas/Irish Channel neighborhoods are lack of providers to the low-income population (more pronounced since Hurricanes Katrina/Rita), and the health status of the at risk population. In discussing need, consideration goes beyond population and demographics. Following Hurricane Katrina, Orleans Parish health care was basically shut down, including the Charity Hospital system that had provided the preponderance of health care to the under and uninsured. The Charity Hospital system remains seriously compromised, placing a significant burden on existing Orleans and Jefferson Parish hospitals and other providers for primary care. Primary care is being rendered in higher cost hospital emergency rooms rather than more appropriate and lower cost modalities such as FQHCs.

The Plan's Critical Issue III called for the need for a neighborhood-based delivery system design, which focuses on primary care need priorities and physician supply specific to planning district and neighborhood level. We are advocates of a neighborhood-based delivery system design and certainly, our St. Thomas/Irish Channel neighborhood sorely needs further primary care development.

We at St. Thomas Community Health Center have been collaborating with the St Charles Community Health Center, a multiple service site FQHC network operating in multiple parishes. Under the administration of Mr. Mark Keiser, the organization's Executive Director, this organization provides comprehensive primary care, behavioral health care, and oral health care to the low-income population, including individuals in contiguous Jefferson Parish from their service site in Kenner.

A natural extension for St Charles CHC and for us at St. Thomas Community Health Center is to collaborate relative to the provision of health care in our own neighborhood. Our respective boards have endorsed a memorandum of understanding defining shared services between the two entities. Part of our strategic planning process is to work with a New Orleans private, non-profit foundation and engage a consulting firm to perform a detailed document relative to needs assessment, capacity building,

patient origin, financial/clinical feasibility, etc. This process is scheduled to commence in May 2007.

We plan to use this information to help us decide what type of the FQHC status we would try to achieve. As we do so, we would envision our plans having the support of the community, political leaders and other providers, including existing FQHC providers such as EXCELth, Inc. and St Charles Community Health Center. We have been discussing our potential application with both Mr. Andry, of Exhealth, and Mr. Keiser, of St Charles Community Health Center, and plan to work collaboratively with both, as well as other community agencies. We anticipate that if we receive support by the other organizations and prove the merit of the application, along with proving that capacity has not been achieved and that there is no overlapping of service areas by providers, that HRSA will approve our project.

We would appreciate your support of St. Thomas Community Health Center in this endeavor to provide much-needed primary care access to our service area population in St. Thomas/Irish Channel. If you desire additional information, please contact me at 504-957-4068.

I would also express my profound appreciation for the concern you have shown to the recovery of the New Orleans area and to the health of our community. The hearings you held, and the questions you have raised, have promoted a very health discussion regarding optimum health care delivery for our community.

Donald T Erwin, M.D.

Donald T Erwin, M.D.
CEO/President, St Thomas Community Health Center
New Orleans, La.

TESTIMONY OF FREDERICK P. CERISE, M.D., M.P.H.

Mr. Chairman and members of the committee thank you for the opportunity to testify today on the continuing concerns and immediate health care needs in the New Orleans region. I am Dr. Fred Cerise, Secretary of the Louisiana Department of Health and Hospitals, the leading State agency for health care in Louisiana.

Background: Louisiana struggles with the same health care delivery system issues affecting the rest of the country. Our fragmented system that operates largely in a fee for service environment results in a health care system characterized by uneven quality of care, rising costs and inequitable access to care. In 2004, Louisiana spent \$19.4 billion on health care services in Louisiana¹ and from 2000–06 health care premiums for Louisiana families grew nearly 5 times faster than earnings.²

In many areas, capacity and utilization in Louisiana are well above the national average. A snapshot of the status in Louisiana prior to Hurricanes Katrina and Rita shows the following:

- Overall Medicare spending per capita³ K—1st
- Hospital beds per capita—9th
- Medicare hospital days—2d
- Overall hospital admissions—4th
- Overall emergency department visits—4th
- Medicare home health, number served per capita—1st
- Medicare home health, number of visits per person served⁴
- Overall prescriptions filled for children and elderly—3d
- Overall Medicare quality ranking⁵—50th

Louisiana is further characterized by a high uninsured rate, a high level of poverty, and poor health status. The uninsured consume far less care than those with insurance,⁶ they are not the driving force behind the above statistics.

The largest provider of care for the uninsured is Louisiana's State operated system run by the Louisiana State University (LSU) Health Care Services Division (HCSD) and Health Sciences Center (HSC). This system is comprised of 10 hospitals and over 250 outpatient clinics statewide. LSU-HCSD, which includes New Orleans, had nearly 900,000 outpatient visits, including 626,000 clinic visits during the 2005–06 fiscal year.⁷

Reimbursement for these services is primarily funded by utilizing disproportionate share hospital (DSH) funds. The DSH program was created to provide funding to hospitals that served a "disproportionate share" of Medicaid and uninsured patients and is a component of the Medicaid program. Subsequently, it is jointly funded by the State and Federal Governments. Louisiana's "State match rate" is approximately 30 percent—so for every 30 cents the State puts forward, the Federal Government matches it with 70 cents. Additionally, each State has a DSH cap. The total DSH available for Louisiana in fiscal year 2007 is \$1.05 billion.

DSH funds in Louisiana are primarily allocated to the LSU system and community hospitals. Although DSH funds are a key source of funding for the uninsured in Louisiana, there are some limitations to the program. For example, only hospitals can be reimbursed with DSH funds. This means that only hospital-based clinics can receive reimbursement through the DSH program. This is less of an issue for the LSU system, since it is an integrated system with both hospitals and clinics. However, the DSH program inadvertently supports high-cost emergency department care when primary care through a clinic might be more appropriate. Furthermore, DSH funds are used for reimbursing health care services—but cannot be used to reimburse a physician or other health care professionals that provide care to the uninsured.

Louisiana is not unique in the existence of this type of safety net; we are unique in that it is organized as a statewide system. Through this system, people who are unable to afford health care can access services, including primary, preventive and specialty care as well as hospital services. While variable across the State, access to many services is constrained by available funding.

Considering the high utilization, rising costs, uneven quality, and lack of equitable access to health care in Louisiana, the State's approach to health care reform, both pre- and post-Katrina has been aimed at making systemic changes.

Louisiana Health Care Redesign Collaborative: After Hurricane Katrina, the Louisiana Health Care Redesign Collaborative was created through a legislative resolution to respond to the health care issues in the New Orleans region (Jefferson, Orleans, Plaquemines, and St. Bernard parishes). The Collaborative was a forty member group charged with creating recommendations for a health care system for New Orleans driven by quality and incorporating evidence-based practices and accepted standards of care. The Collaborative adopted the following vision: Health care in

Louisiana will be patient-centered, quality-driven, sustainable and accessible to all citizens. The backbone of a redesigned system of care put forward by the Collaborative is the “medical home.”

The proposed medical home system is consistent with recommendations made by a number of professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians. It also has qualities and expectations consistent with those of a high performing health system as described by the Commonwealth Fund and of a redesigned system as characterized by the Institute of Medicine.

This new system will provide health promotion, disease prevention, health maintenance, behavioral health services, patient education, and diagnosis and treatment of acute and chronic illnesses. The medical home is the base from which other needed services are managed and coordinated in order to provide the most effective and efficient care. This includes specialty care, inpatient care, community preventive services and medical home extension services for complex care needs. The center of the medical home is a primary care provider who partners with the patient to coordinate and facilitate care. The medical home does not restrict patient access to services—rather it helps ensure that the patient receives the right services.

Ensuring the coordination and comprehensive approach of the medical home model over time will improve the efficiency and effectiveness of the health care system and ultimately improve health outcomes.

The other three main components of the redesign concept are:

- **Health Information Technology (HIT)**—HIT is the key to creating “system-ness” and can allow the seamless sharing of electronic information to improve efficiency and patient safety. Additionally, HIT can be used to inform clinical practices and facilitate data reporting which are key components of a quality agenda.

- **Louisiana Health Care Quality Forum (LHCQF)** “The LHCQF will function as a “learning system” that will monitor population health measures across providers and payer systems and actively engage with health care organizations to implement quality improvements, increase cost-effectiveness, and achieve better outcomes statewide. It will improve the quality of health and health care throughout Louisiana in a cost effective and transparent manner in a safe, peer protected environment.

- **Coverage for Services** - Another major concept is the creation of a mechanism (the Connector) which would match individuals needing health insurance to affordable insurance options, thus offering affordable health insurance coverage to an expanded number of uninsured individuals in the State.

In response to the Collaborative’s concept, the Federal Department of Health and Human Services put forward a proposal that is consistent with the President’s Affordable Choices Grants proposal that was announced in the 2007 State of the Union address. HHS proposed a statewide coverage expansion that would insure 319,000 uninsured through private insurance. This proposal would be financed by savings from better managing Louisiana’s Medicaid program and by redirecting \$770 million in disproportionate share hospital (DSH) funds currently spent in the safety net system.

While appreciative of the effort to insure more individuals, the State recognizes serious gaps in the proposal. Through our analysis, the HHS proposal would leave 300,000 to 400,000 citizens without insurance coverage. Additionally, current funding (\$770 million) for the safety net would be eliminated if the State were to implement the CMS proposal. The use of incorrect cost projections, the omission of high-cost populations, and the use of unrealistic managed care discounts in the HHS proposal suggests that coverage would be expanded to fewer than the projected 319,000.

Louisiana has learned from those that have traveled this road before. Massachusetts, which is breaking ground with its mandate for health insurance coverage, spent many years working towards this goal. If Louisiana were to cover half of its uninsured as optimistically described above, we would end where Massachusetts began just prior to its 2006 reform legislation—about 10 percent uninsured but without a safety net system of care. As a State with nearly 18 percent uninsured and 45 percent of its population at 200 percent of the Federal Poverty Level or below,⁸ we understand that we must lay the groundwork before we can make such great leaps. The groundwork includes efforts aimed at both insuring more people, and also, very importantly, improving our safety net and the delivery system in general.

John Wennberg, Director of the Center for the Evaluative Clinical Services at Dartmouth Medical School, and others have demonstrated that in healthcare, capacity is a strong driver for demand. As a result of Katrina, the New Orleans region

lost a large amount of capacity. However, capacity is tied to other important pieces of the utilization equation, such as how care delivery is coordinated and how it is reimbursed.

Those system design changes have not occurred; therefore we should not expect a smooth transition to a lower capacity system. Further, in most areas, capacity is now well below national norms. The lower capacity and specifically, the lack of ready access to coordinated primary care or post-acute care, has resulted in the stressed medical environment we are experiencing today in New Orleans.

So our challenge is twofold. We must first meet immediate needs while ensuring that, in the process, we support the rebirth of a better overall system of care. The vision for a system to replace the lost capacity is one that adheres to the aims set forth by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable. It is a patient-centered system predicated on access to primary care that provides evidence-based preventive services and tracks those with chronic disease to ensure appropriate management. It provides ready access to appropriate services and information when necessary and is convenient for patients, coordinated among providers along the continuum of care, and supported by a system of electronic medical records to improve safety, quality and efficiency.

The current gaps in the delivery system have provided the opportunity for systems change. We will continue to move forward with health care reform for Louisiana—but we must also ensure the New Orleans region can recover to meet our citizen's health care needs today. My testimony today will focus on the immediate and short-term health care needs for the New Orleans region of Louisiana.

Post-Katrina Health Care in the New Orleans Region: Hurricane Katrina caused a significant disruption in the health care delivery system in New Orleans. Prior to Katrina, care for the uninsured in the New Orleans region was delivered primarily in the public hospital system and clinics and to a lesser extent, federally qualified health centers (FQHCs). Uncompensated care for the community hospitals in the region was less than 4 percent. According to the PricewaterhouseCoopers Report on Louisiana HealthCare Delivery and Financing System, the region had an oversupply of short-term acute care hospital beds and an undersupply of long-term care beds.

Immediately after the storm, only 7 of 21 acute care hospitals were open with staffed beds at less than half of the pre-Katrina total. The nursing home capacity was reduced from 4,954 to 2,735 beds. The largest health care system for the uninsured, the LSU-HCSD system, was not operational.⁹ The closure of the LSU-HCSD hospital in New Orleans also eliminated their Level I trauma center, which was one of only two in the State. In addition to the impact on the infrastructure, the evacuation of people from the area led to the largest efflux of health care providers in U.S. history.

The University of North Carolina at Chapel Hill estimated that almost 6,000 active, patient-care physicians along the Gulf Coast were dislocated by the storm. Over two-thirds—4,486—of those were in the three central New Orleans area parishes that were evacuated. The study also estimates that over 35 percent of these dislocated physicians were primary care physicians. The loss of medical manpower in hurricane-affected areas created a critical shortage of physicians all across south Louisiana. Similar shortages have occurred with nurses and other licensed and trained health care providers.

There have been a number of efforts over the past year and a half to ameliorate the situation in the New Orleans region. The Federal Deficit Reduction Act appropriated \$2 billion to States affected by Hurricane Katrina. As a result, the State implemented a Katrina 1115 waiver to provide coverage to our citizens that evacuated to other States and to provide payment to providers within the State for uncompensated care (UCC). This provided \$132,091,048 in much needed relief to providers for uncompensated care between August 2005 and January 2006.

Additionally, the State was able to use approximately \$680,569,383 to supplement State funding for its Medicaid program. The Medicaid funding relief came at a critical juncture in early 2006 as State revenues had sharply declined, all State agencies were implementing budget reductions, and the State had issued an emergency rule reducing Medicaid reimbursement rates to providers by roughly 10 percent.

Hospitals: Recognizing that the usual source of inpatient care for the uninsured in the Orleans region was not operational and that the Katrina UCC pool was time limited, the State created a mechanism to pay community hospitals for UCC rendered for the remainder of the State fiscal year, between February and June 2006. A total of \$52,494,904 was reimbursed to community hospitals. Currently, physician costs are not considered an allowable cost and cannot receive reimbursement through the DSH program. A request to receive Federal match to pay physician UCC during this period was requested but not approved.

Two payment increases were subsequently approved by the 2006 Louisiana Legislature. First, Medicaid payments for hospitals were increased by \$38 million. Second, a Community Hospital DSH Pool was established, allocating \$120 million for UCC for community hospitals from July 2006 through June 2007. Although a proposal was put forward by the State to reimburse hospitals in the Katrina and Rita affected parishes at 90 percent of uncompensated care costs, the hospital association preferred an approach that provided less funding to the Katrina and Rita affected regions and spread the UCC funds more thinly across the State to potentially include all hospitals in the State, including those not in the affected regions and not significantly impacted by evacuees.

To date, \$37,995,972 has been paid to the community hospitals; it is likely that the full \$120 million will not be expended according to the formula adopted in the State appropriations bill.

Primary Care and Behavioral Health: Access to primary care and behavioral health has been limited post-Katrina. This is particularly true for those without insurance. Approximately \$16.5 million of the Social Services Block Grant (SSBG) funding was dedicated to restoring primary care in the New Orleans region after Hurricane Katrina to restoring critical primary and preventive health care services. This funding expires August 2007. In addition to utilizing this funding for direct service delivery, SSBG funding also has been used to enable these clinics to prepare to become future medical homes delivery sites. The State targeted a portion of SSBG funding to the implementation of electronic medical records, quality improvement initiatives and the development of networking capabilities across clinic sites to achieve interoperability and system-wide patient education and outreach.

SSBG funds are also being used to restore and expand mental health services, substance abuse treatment and prevention, and developmental disability services for children, adolescents and adults in need of care in these areas. Through this funding, efforts are also being targeted at the creation of more appropriate community based treatment options to prevent unnecessary or inappropriate institutional care.

Federal Emergency Management Agency (FEMA) and Substance Abuse and Mental Health Services Administration (SAMHSA) funds have been used to:

- provide psychological debriefing and stress management interventions to the public sector workforce;
- expand the number of addiction counselors in the State; and
- develop and implement the “Louisiana Spirit—Immediate Crisis Services Program, which is designed to deliver crisis and mobile counseling to persons impacted by the hurricanes.

The State has also provided funding to open 45 beds for behavioral health for adults and children.

Health Care Workforce: The Redesign Collaborative identified a number of short-term issues and made requests to HHS for assistance, including one to establish the Greater New Orleans Health Services Corps (GNOHSC). A major challenge remains the inability to retain a medical workforce. HHS awarded Louisiana with a workforce grant of \$15 million in February 2007.

The grant, through the GHNOHS, will provide salary, relocation costs, bonuses, and premium payments for medical malpractice for providers that commit to practice in the region for the next three years. Eligible providers include physicians, dentists, physician assistants, nurse practitioners, nurse midwives, dental hygienists, psychologists, counselors, social workers and pharmacists.

New workforce competition, as a result of Katrina, has highlighted traditionally low salaries of direct care professionals for the elderly and people with disabilities. The average salary for direct support professionals in Louisiana is \$6.68, which is below the national average. The State is increasing the wages for these workers by \$2/hours to help retain these critically needed workers. The annual cost to Medicaid will be \$110 million.

Another short-term request from the Collaborative to HHS was for an adjustment to the Medicare wage index to reflect current costs. The wage index typically lags three years. Hospitals estimated the cost to be \$67.7 million a year for three years. A \$71 million grant to hospitals and skilled nursing facilities was received from HHS.

Health Information Technology: Louisiana received a \$3.7 million contract from the Office of the National Coordinator for Health Information Technology (ONCHIT) to develop a prototype for health information exchange, which has since been successfully demonstrated. This contract is part of the Gulf Coast Digital Recovery Effort. The State assisted in the establishment of the Gulf Coast Health Information Technology Task Force that the Southern Governor’s Association convened. Other

HIT efforts include the launch of KatrinaHealth.org which allowed providers to access prescription drug information for evacuees.

Current Status of the System: Combined, these efforts have significantly improved health care in the New Orleans region. However, issues remain. Over time, the impacted area has seen slight increases in bed capacity, but there remains a shortage of acute care beds compared to national standards. The current plan in the LSU-HCSD hospitals is to phase-in an additional 75 beds by July 2007. The staffing and reimbursement for hospitals continue to pose problems.

Today, there are 26 safety net primary health care sites that are providing services in the New Orleans region. These sites include federally qualified health centers, Tulane outpatient clinics, LSU-HCSD outpatient clinics, mobile clinics, city and parish health service sites, hospital outpatient clinics, rural health clinics and non-profit community-based practices. However, based on the current population, there remains a shortage of primary care providers. Increased demand for primary care providers will likely occur as the region continues to repopulate.

The region also suffers from a significant shortage of specialists. While LSU-HCSD has been able to resume a number of specialty services as space and staff have become available, there remains the lack of some essential specialty services to support the primary care sites serving Medicaid and the uninsured. The area is still below national norms for nursing facility beds.

Immediate Health Care Needs for the New Orleans Region: The health care system is still challenged today. The actions taken over the past year and a half have helped to improve access to care, workforce issues and infrastructure—but problems remain. Access to care, particularly for the uninsured, is difficult. Rising costs, due to contract labor and higher property and casualty insurance costs are impacting providers. The average length of stay in hospitals is above pre-Katrina averages. These are among the immediate needs to be addressed in the New Orleans region.

Broadly, the immediate continuing needs fall into one of three categories: access to care, workforce recruitment and retention, and infrastructure requirements. The specific needs are outlined below:

Primary Care Capacity: Currently, there is a shortage of primary care providers in the New Orleans region that is affecting all other components of the system. Based on HRSA standards, we have a shortage of 49 primary care providers who are available and willing to serve the Medicaid and uninsured populations. Hospitals across the region report seeing a population with more advanced disease than pre-Katrina, more patients without a regular source of care, and even more limited options for discharge and follow-up care in the communities.

Solution: Establish sufficient primary care capacity in a manner consistent with the redesigned system of care envisioned by the Collaborative by sustaining operational support provided by SSBG funds to safety net clinics and by funding ten new medical homes. Medical Homes of sufficient size and scope to meet the needs of the uninsured population will be established in a fashion consistent with the principles outlined by the Collaborative. The medical home criteria would include not only quality expectations but also care coordination and access expectations to ensure timely care is available outside of emergency departments through after hours clinics.

The above approach will have the effect of providing assurances of income necessary to attract and retain providers, while relieving the burdens of fixed costs. This will foster the growth of what is designed to be a high performance delivery system.

Workforce Recruitment and Retention: Louisiana facilities now have to employ increasing amounts of contract labor to sustain staffing needs. The added complexity of inadequate and short supply of desirable housing for health care professionals continues to result in a lack of physician staff, mental health professionals, dentists, nurses, and others willing to remain in or locate in the greater New Orleans area. The ability to expand capacity to meet the health care needs in the region is hindered by the lack of available workforce.

Solution: Fully implement the Greater New Orleans Health Services Corps Program. Initially, Louisiana requested \$120 million to support health care workforce recruitment and retention. Fifteen million dollars have been granted to the State—which will allow the State to institute the program. However, we continue to estimate that it will cost \$120 million to fully implement the program. This will provide for incentives for physicians, dentists, nurses, and other professional staff. In exchange for the financial support, providers must commit to serve in the region for three years.

Behavioral Health: Lack of access to necessary community based services and housing supports for individuals with mental illness and other behavioral health needs shifts care to more acute services. The shortage of community services for this

population, a situation only exacerbated after Hurricane Katrina, results in the reliance for services on the hospital emergency departments, an area already strained due to the lack of adequate primary care in the area. In addition, the loss of psychiatric care beds in the area from 274 to 180 post-Katrina and the slow return of the community based mental health services only furthers the lack of access to care.

Solution: Develop, implement, and fund a five year redevelopment and mitigation/prevention plan for behavioral health services; and expand Medicaid coverage to people with severe mental illness. The State requests a partnership with FEMA and other governmental entities in the development and implementation of a point by point plan along with secure funding for a five years. This plan allows for the reestablishment of a competent mental health system in the greater New Orleans region and other contiguous parishes.

This five year plan, estimated at \$170,000,000 would include crisis counseling under the existing FEMA Disaster Relief, as well as direct treatment dollars for services including psychiatric hospitalization, crisis intervention, suicide prevention, substance abuse treatment and long-term ambulatory treatment of psychiatric conditions. This funding and support from FEMA will stabilize the behavioral health system for the Orleans region.

Further, the concept paper the State put forward to HHS included a request to include individuals with serious mental illness as a Medicaid eligible population. This would allow the State to provide broader access to services for these individuals.

Medicare Wage Index: The short supply of health care providers is resulting in increased competition among providers for professional and non-professional staff. The effect is a significant rise in labor costs. Compounding the problem is the increase in the length of stay that hospitals are reporting. This rise in costs is not reflected in the prices established by the Medicare fixed payment system.

Solution: Provide funding for costs related to the Medicare wage index. HHS awarded Louisiana a \$71 million grant for hospitals and skilled nursing facilities to address the increased costs providers are experiencing as a result of the rising labor costs. While very helpful, this one time grant does not address the entire three year lag in the Medicare wage index calculation. The fiscal estimate for 2 years is \$67 million/year for hospitals and \$6.9 million/year for skilled nursing facilities.

DSH Flexibility: Two significant roadblocks to increasing health care capacity and access to health services in the New Orleans region are (1) the inability to use DSH funding for non-institutional care and (2) the inability to use DSH to reimburse for physician services. In order to receive DSH funds today, health care services must be funded by a hospital. While the State has created great capacity in a clinic system associated with public hospitals, this limits flexibility in development of outpatient capacity. Further, while physician costs are an essential component of delivering health care, they are not reimbursable through DSH.

Solution: Allow the redirection of DSH funds to support non-institutional care; and allow DSH funds for physician services. The DSH redirection will provide great relief by creating a funding mechanism to reimburse physicians for treating the uninsured and by supporting clinics that provide primary and preventive care. The State also proposes to redirect DSH funds in the New Orleans region for a pilot to reduce the cost of private insurance for small employers and their low-income employees. Ultimately, redirecting the DSH funds will allow the groundwork for creating an integrated system of care for the New Orleans region. This solution does not require additional funding.

Health Information Technology (HIT): Hurricane Katrina highlighted the importance of interoperable HIT. After the storm, providers had difficulty communicating with each other across the State and the vast majority patients who were displaced as well as the providers caring for them did not have access to patient records. While HIT is an important component of hurricane preparedness, it creates value everyday by improving patient safety and health system efficiency. As physician practices recover, and as we support providers in settings to care for the uninsured, it makes sense to implement a modern system of health information exchange into the process. The devastation in the New Orleans region provides an unprecedented opportunity to make a significant imprint of HIT in a large metropolitan area.

Solution: Support electronic medical record (EMR) adoption and continue to support the Louisiana Health Information Exchange (LaHIE) project. The Office of the National Coordinator for Health Information Technology contracted with Louisiana immediately after Hurricane Katrina to develop a health information exchange, as part of the Gulf Coast Digital Recovery effort. This \$3.7 contract will expire at the end of this month. Continued support of LaHIE will cost approximately \$1 million per year. The other essential component is the adoption of EMRs by providers. The State estimates that it will cost \$17.7 million over a five year period for the New

Orleans region primary care providers to fully adopt EMRs. The State is would like to continue and expand this successful partnership with the Federal Government.

Developmental Disabilities: The ongoing need for community-integrated housing that can support those with significant disabilities is critical for the recovery and for the healthcare delivery system in south Louisiana. Prior to Hurricanes Katrina and Rita, people with disabilities were disproportionately represented among the homeless and faced extraordinary barriers in accessing and maintaining access to affordable housing. As a result of the disaster, many more have been rendered homeless or have been unable to move from what should have been temporary shelter in institutions and other restrictive settings because of a lack of affordable housing coordinated with supportive services. This also affects the ability of healthcare providers to discharge individuals from acute care settings, and housing instability often leads to a revolving door of reentry into emergency and acute care services.

Solution: Provide, through the U.S. Department of Housing and Urban Development, an equal number of Section 8 project-based Housing Choice Vouchers to be used in conjunction with the 3,000 units of Permanent Supportive Housing (PSH). Louisiana has made a commitment to develop 3,000 units of Permanent Supportive Housing as part of the recovery effort. The State has worked closely with local and national advocates who are strongly in favor of this commitment to PSH. These vouchers will ensure that the housing designated for PHS will, in fact, be affordable to individuals with disabilities, many of whom live on SSI and have incomes at and below 20 percent of Area Median Income. In order for this recovery to be accessible to all Louisianans, the Federal Government's provision of 3,000 section 8 project-based Housing Choice Vouchers specifically for use in providing PHS as defined in the Louisiana Road Home Plan is essential.

PSH integrates affordable, mainstream rental housing with the supportive services needed to help people with disabilities access and maintain stable housing in the community. This model is a nationally recognized, cost-effective model for preventing and ending homelessness and unnecessary institutionalization among low-income people with serious, long-term disabilities including mental illness, developmental disabilities, physical disabilities, substance use disorders, chronic health conditions like HIV/Aids, and chronic conditions and frailty associated with aging.

Thank you for the opportunity to testify today.

¹ PricewaterhouseCoopers, "Report on Louisiana Healthcare Delivery and Financing System," 2006.

² Families USA, "Premiums Versus Paychecks: A Growing Burden for Louisiana's Workers," December 2006.

³ S.F. Jencks, et al, "Change in the Quality of Care Delivered to Medicare Beneficiaries," JAMA, 2003.

⁴ Kaiser Family Foundation, State Health Facts—Louisiana, available at: www.statehealthfacts.org (accessed March 9, 2007).

⁵ Jencks

⁶ J.R. Graham, "Don't blame the uninsured," Chicago Tribune, March 2007.

⁷ LSU-HCSD, "LSU-HCSD Fiscal Year 2005–2006 Utilization Report," May 2006.

⁸ Kaiser Family Foundation, State Health Facts—Louisiana, available at: www.statehealthfacts.org (accessed March 9, 2007).

⁹ PricewaterhouseCoopers, "Report on Louisiana Healthcare Delivery and Financing System," 2006.

TESTIMONY OF CATHI FONTENOT, M.D.

I would first like to thank members of the subcommittee, including Chairman Stupak and Ranking Member Whitfield, who have taken time out of your busy schedules to travel to New Orleans to witness first hand the destruction wrought by Hurricane Katrina. Thank you for your attention and for this opportunity to share our current state of affairs and plans for the future to support the health care infrastructure in New Orleans.

I am medical director of the Medical Center of Louisiana at New Orleans (MCLNO), which is comprised of both Charity and University Hospitals. MCLNO is part of a State-wide system of public hospitals and clinics with a principal mission to provide access to care for the uninsured. MCLNO and LSU's other hospitals also play an integral role in health care education in Louisiana, housing the vast majority of residency training slots in the State. The strong linkage of graduate medical education and care for the uninsured has been a signal feature of Louisiana's health policy for many years.

Prior to August 29, 2005, MCLNO provided approximately 270,000 outpatient clinic visits which spanned primary care to specialties, such as nerve surgery and cardiothoracic surgery. It housed one of the largest HIV outpatient clinics in the country and provided 130,000 outpatient emergency room visits. It was one of only two Level 1 Trauma Centers in the State of Louisiana, the other being in the northern part of the State in Shreveport, and served as a primary training site for both LSU and Tulane Schools of Medicine. In addition to future physicians, the Medical Center was responsible for training multiple other health care providers, including nurses and allied health providers such as physical therapists, occupational therapists and respiratory therapists. The Medical Center had a capacity of about 550 beds, including almost 100 psychiatric beds, with occupancy that hovered between 90 percent to 100 percent. You will rarely see such a full census in any hospital, except in urban public hospitals.

The storm effectively destroyed both MCLNO facilities. The loss of Charity and University Hospitals has been devastating to the community. The current status of health care infrastructure in New Orleans is tenuous and critically ill. Although we were able to temporarily re-open a portion of University Hospital, restoring approximately 180 inpatient beds, the total number of beds in New Orleans is less than half of pre-Katrina numbers. The population loss, while high within New Orleans city limits, is actually close to pre-Katrina levels in the metropolitan area overall. Many have simply relocated to higher ground but remain in the market. Sicker patients, who in many cases have lost their health care providers, present to our emergency rooms with uncontrolled disease processes due to lack of primary care and access to medications. Because of the loss of clinic space and cancer providers, patients who present to our hospital with cancer and no health insurance have no choice but to travel 60 miles to a rural LSU hospital for their chemotherapy or radiation treatments and back 60 miles home while weak and miserable (and that's assuming they have transportation).

The status of behavioral health is even more dismal with limited outpatient and inpatient services in the greater New Orleans area. Emergency rooms across the city are bearing the brunt of this shortage with anywhere from 10 to 20 psychiatric patients occupying acute emergency beds on any given day. In our emergency room alone there are days when half of our available Emergency Department beds are occupied by psychiatric patients because there are no inpatient beds available for them. This situation is unsafe and certainly not in the best interest of the patients or our employees. It also results in a major obstacle to Emergency Department through-put for acute care. Local emergency rooms are already overwhelmed with patients who seek primary care inappropriately through the Emergency Department because of loss of health care providers in the area, and the addition of behavioral health patients to this mix is simply not good medicine.

Solutions to the health care crisis in New Orleans are being developed but are constrained by availability of space and health care providers (both primary care and specialty providers). A critical component of the effort to restore health care services involves establishing and strengthening a network of neighborhood clinics. MCLNO has continued our collaborative coalition with the group of primary care clinics known as PATH, Partners for Access to Healthcare for the Uninsured, where we serve as the major hospital partner and provide hospital services as well as specialty access. It is this sort of collaborative effort that can be a real opportunity to accomplish health care reform as we go forward. Additionally, the plan for the Medical Center includes establishment of community primary care clinics in temporary facilities so that primary care can be delivered in communities where the basic principles of prevention and disease management are best delivered. One of the major challenges for health care providers in the New Orleans region is the lack of access to specialty care. We anticipate that at least to some degree, we can maximize the use of the limited specialty care available by utilizing telemedicine technology and becoming more efficient at directing patients to the right place at the right time for the right reason. Additionally, a shared electronic record is critical to such a network of providers in order to share information and eliminate costly duplication of effort.

We look forward to continuing our work with other safety net providers because such a coalition is crucial to real health care reform and necessary for institution of a new model of health care in the region.

Thank you for the opportunity to share our information with you today.

TESTIMONY OF THOMAS KOEHL

Chairman Stupak and distinguished members of Congress and guests. Thank you for the opportunity to speak to you today.

My name is Thomas Koehl and I work for Operation Blessing, a humanitarian relief organization that responds to both domestic and international disasters. Among other activities, Operation Blessing provides a free medical and dental clinic as well as a pharmacy in New Orleans. We presently see 75 to 100 patients a day with a staff of volunteer doctors, nurse practitioners, and physicians assistants. In the past 11 months we have provided healthcare to over 15,000 patients and dispensed 25,000 free prescriptions to the residents of this stricken city.

They were pulled from roof tops, they waded in water, and spent days sweltering in the heat on highway overpasses and in the superdome. They are a never before seen American, over 100,000 newly made poor, hopeless, homeless and marginalized. Our task—yours and mine—is to relieve their suffering.

When Katrina struck, it washed away people's homes, jobs and health insurance, but not their high blood pressure, diabetes, and other chronic illnesses.

The need for healthcare is so great that our patients begin standing in line at three and four o'clock in the morning every week day in order to see a healthcare provider. Grandmothers, single mothers with sick children, entire families sleeping in the cold to wait to see a doctor. They are uninsured, working for employers that do not provide benefits, and not old enough to qualify for Medicare or not accepted by the States' Medicaid program.

Operation Blessing recently partnered with Remote Area Medical, International Medical Alliance, the New Orleans Health Department and the LA Department of Health and Hospitals to host Medical Recovery Week for the greater New Orleans Area.

On the first morning of this event I met Mike in our triage area. He made his way through a maze of tents, concentrating on staying warm and keeping his place in line. He was one of hundreds who had arrived in the frigid pre dawn hours in the hopes of seeing a doctor. Mike had been in line since 10 pm the night before. I asked Mike why he was there and he said, "I need insulin, I have been out for months and haven't found anyone that could help."

Like thousands of returning hurricane evacuees, Mike had returned to a city where health care was limited and the majority of residents are now uninsured. "This was a new reality check for me," Mike said. "My insurance is gone, my job is gone, and my home is gone."

On this day, however, he along with nearly 600 other patients received free medical care during Operation Blessing's Medical Recovery Week.

More than 400 doctors, dentists and nurses flew in from across the country to volunteer for the event, providing more than 9,000 medical services to more than 3,000 patients by the week's end. Services included dental work; eye exams and glasses; primary healthcare; OB/GYN services, diabetic care, pediatrics and cardiology.

To accommodate the influx of patients, we set up 20,000 square feet of tent space to serve as additional exam rooms outside the Operation Blessing medical and dental clinics—which have been providing free medical care to more than 15,000 Katrina victims since April 3, 2006.

This was simply a larger version of what we do everyday in New Orleans. For Mike, help was as simple as receiving a new meter to test his blood sugar and several vials of insulin.

It's not uncommon day-after-day to hear people sit and cry and say, I worked across the street at the hospital 24 years. I had insurance, I had retirement, and it's gone. The population that we are serving is not just those who were poor before Katrina, but tens of thousands of newly-made poor . . . people who had jobs, cars, homes, and health insurance.

Our patients still, 18 months after Katrina, get in line before daylight every week-day to receive healthcare. Over 50 percent of these patients have High Blood Pressure and a third of those are in crisis when they arrive at our door. 26 percent of our patients have diabetes and many blood sugars are so high when they walk through our door that they cannot be measured. We still see two to three patients a week that have not had their insulin since Katrina and have just heard about our clinic.

These citizens are not what you would classically think of when you think of indigent patients. These citizens just 18 months ago owned their own homes, worked fulltime, went to the children's band performances and volunteered in their community. They were people just like your neighbors. People you would have invited to your home for dinner.

Would you feel comfortable if your neighbors had to stand in line all night in the cold to be seen by a doctor? Or be sent to a hospital and have to wait in an ambulance for 4 hours before they can be seen in the emergency room. The question then is who is our neighbor. Is it just the family whose grass meets ours or should we be concerned about those Americans that we have not yet met.

This population is our modern day Job. They have lost loved ones, their homes, their cars, their jobs, and their insurance. We have 127,000 uninsured residents in the city of New Orleans. They see others profiting from a disaster in which they lost everything, including their faith in a system which had promised them health insurance, a pension and, most importantly, protection.

Today the mortality rate in New Orleans is 48 percent higher per capita than it was before Katrina. I am not talking about traumatic injury but death caused by heart attack, diabetes, and stroke. The infant mortality rate in New Orleans is five times higher than it was before the storm. The level of depression is present at rates never before seen in the United States of America. The depression and stress act to worsen and exacerbate individual healthcare issues and disease processes.

We are here to discuss what needs to be done going forward.

Build a system where it is easier for non-profit agencies to operate in disaster stricken areas. Operation Blessing can provide its own infrastructure, but not all non-profits are able to provide buildings and appropriate utilities so they can care for the victims of disaster.

Build a system that encourages for profit providers to return to the region, where "the dollars follow the patient," where the uninsured have choices and can seek care in private health care facilities and those doctor's offices and hospitals are reimbursed for that care. The charity hospitals would have to compete with private hospitals to survive and would raise the overall level of patient care in the region.

Among the recommendations being considered to improve primary and preventive care are technology initiatives to track a person's medical history and to create community clinics, health centers and other neighborhood facilities to coordinate care for those who depend on the State for services. The community clinics would refer patients to specialists, manage disease care and provide a consistent system for tracking care.

Please remember that everything that is needed by the city of New Orleans is also needed by the healthcare system that you seek to rebuild. Infrastructure such as housing, schools for the doctors and nurses children, utilities, and people with the economic ability to pay for the service that is being offered. All of these are necessary for a sustainable healthcare system.

Since April 3, 2006, Operation Blessing has provided free medical and dental services to more than 15,000 residents devastated by Hurricane Katrina and filled over 25,000 prescriptions free-of-charge. We can only do this by partnering with other agencies and with the financial support of our donors. I would like to thank all who have made it possible for Operation Blessing to care for the residents of New Orleans. We are truly grateful for the opportunity to serve.

STATEMENT OF ROBERT E. LYNCH, M.D.

Mr. Chairman and members of the committee, I want to start by thanking you for the universal support the United States Congress has given to the Department of Veterans Affairs (VA) in its rebuilding and recovery efforts not only in southeastern Louisiana but also the entire Gulf Coast region. Through that support, our veterans and the VA employees living along the Gulf Coast continue to make great strides along the road to recovery.

Hurricanes Katrina and Rita challenged our country with two of its greatest natural disasters. While Hurricane Rita did little permanent damage to VA's infrastructure, Hurricane Katrina, on the other hand, produced unprecedented damage to its medical center in New Orleans. Our medical center, the community we serve, and the homes of veterans and employees sustained destruction on an monumental scale. Today I will describe our ongoing and planned health care restoration efforts in New Orleans.

I will speak first to VA health care recovery activities and its future plans in New Orleans. Next, I will address the Memorandum of Understanding that was signed between VA and the Louisiana State University (LSU) System and actions associated with it. Finally, I will discuss VA's relationship with LSU as the State of Louisiana progresses in its analysis of State health care reform.

NEW ORLEANS RECOVERY ACTIVITIES AND FUTURE PLANS

Forty-eight hours following Hurricane Katrina's landfall, as quickly as weather conditions permitted, a VA damage assessment team was dispatched to the Gulf Region to survey VA facilities at New Orleans, LA; Biloxi, MS; and Gulfport, MS. At New Orleans, the team found that the VA facility initially weathered the storm with minimal damage. However, following the hurricane, water from the breached levees flooded the entire medical district and the medical center. Flooding of the basement and sub-basement in the main building of the VA Medical Center (VAMC) rendered it inoperable as these areas housed the facility's major electrical, mechanical, and dietetics equipment. The medical center's long standing academic partner, the Louisiana State University Health Care Services Division at Charity and University Hospital, sustained similar types of damage. While University Hospital has reopened, Charity Hospital is permanently closed.

In the immediate aftermath of Hurricane Katrina, VA's commitment to the Gulf Coast Region veterans remained steadfast. VA deployed a system of 12 "mobile clinics," in coordination with local authorities, to provide urgent and emergent care to include first aid, immunizations, and prescriptions. Specifically in Louisiana, mobile clinics provided care at Baton Rouge, Hammond, Jennings, Kinder, Lafayette, Lake Charles, LaPlace, and Slidell. VA mobile clinics treated 5,000 veterans and 11,000 non-veterans in the aftermath of Hurricanes Katrina and Rita.

To address the health care of veterans in the greater New Orleans area, VA expanded the capacity of its existing Community Based Outpatient Clinic (CBOC) in Baton Rouge. We converted the ninth and tenth floors of the medical center, formerly the nursing home in New Orleans into exam rooms and began offering primary care services there in December 2005. Three months later in March 2006 limited specialty care clinic services were added to those units. Temporary facilities in LaPlace (St. John's Parish), and Slidell were leased as alternate care sites. Tents were erected in Hammond to provide basic services.

With the support of Congress, VA was authorized to accelerate the activation of CBOCs proposed under CARES and opened a permanent clinic in Hammond in August 2006. We remain in leased space in Slidell and plan to construct a permanent clinic there in three to five years. The St. John CBOC is anticipated to open in October 2007.

Basic outpatient mental health services are provided at each of the clinic locations. Currently, inpatient mental health care is coordinated with the Alexandria (LA) VA Medical Center. Dental clinic services were re-established in April 2006 by leasing space in Mandeville, Louisiana. In Baton Rouge, we leased the old CBOC building in 2006 and are using that facility to house the medical center's clinical laboratory, as well as select administrative support functions.

As a result of these actions, the Southeast Louisiana Veterans Health Care System (SLVHCS), formerly known as the New Orleans VA Medical Center, served over 29,000 veterans in fiscal year 2006. This is 72 percent of the previous year's workload. Fiscal year 2007 workload to date is growing at an annualized rate of ten percent over last year and is expected to increase as housing is restocked in the area.

To help our staff and support the community, VA worked with its academic affiliates, The Tulane University School of Medicine and the LSU School of Medicine, to place VA faculty, medical staff/residents, and student trainees at VAMCs throughout our VISN 16 Network.

With the VA's inpatient units shut down, 102 medical center employees that included nurses, health technicians, medical support assistants, operating room technicians, certified registered nurse anesthetists, and radiology technologists were temporarily deployed in July 2006 under a Federal Emergency Management Agency (FEMA) task order to provide critically needed staff support to local health care institutions.

In terms of future VA services in New Orleans, we continue to explore our long-term options for re-establishing surgical capabilities and inpatient services in New Orleans. In the interim, these services are coordinated through sister VA medical centers in Louisiana, Mississippi, and Texas, as well as through selective referrals to community hospitals in the New Orleans area at VA expense. We are actively pursuing options for expanding outpatient mental health services to meet current and future veteran's needs.

Projects for the re-establishment of radiology and outpatient pharmacy services on the grounds of the old medical center campus are underway and expected to be completed later this calendar year.

In preparation for the construction of a replacement medical center, VA has initiated its space planning process. Interviews of architecture and engineering firms to design the new facility are complete. A selection is expected this spring. The re-

placement medical center is expected to provide acute medical, surgical, mental health and tertiary care services, as well as long-term care.

MEMORANDUM OF UNDERSTANDING BETWEEN VA AND LSU

As required in Public Law 109-148, VA compiled and presented its long-term plans for the construction of a replacement hospital in New Orleans in its February 2006, "Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans." In that report, VA identified its principal objectives regarding the New Orleans area as being not only to restore services to veterans in the most cost effective manner, but also to assist in the restoration of health care and medical education in New Orleans. Recognizing the successful history for sharing and collaboration between VA and the LSU Health Care Services Division, as well as the potential for future efficiencies, the report concluded that construction of facilities on a single campus with support services shared with LSU was the preferred option.

As a result of the "Report to Congress," VA and LSU leadership signed a Memorandum of Understanding (MOU) agreeing to jointly study state-of-the-art health care delivery options in New Orleans. This MOU established the foundation for developing a collaborative approach to operating a replacement facility. From that a group of experts from both organizations, called the Collaborative Opportunities Study Group (COSG) was charged with determining if any mutually beneficial sharing could occur between the two organizations. In the group's June 2006 report delivered to the former VA's Under Secretary for Health, it concluded that both organizations could leverage their strengths, provide significant operating efficiencies, and allow us to better serve our beneficiaries. Congress subsequently authorized VA to pursue the project to replace the New Orleans facility as a collaborative effort consistent with the COSG report.

In September 2006, the Collaborative Opportunities Planning Group (COPG) was established to develop an operational plan for sharing between the two organizations based on the foundation work of the COSG. The COPG is co-led by VA and LSU representatives. Representatives of the Tulane University School of Medicine and the State of Louisiana Division of Administration are also part of this group and its planning discussions.

A critical component of the charge of the COPG is to determine if the proposed sharing options identified in the original COSG report are viable and if they are, to begin the work of developing timelines and formulating the framework for space planning and design for a joint replacement facility. To date the COPG has made significant progress by reviewing literally dozens of clinical and administrative functions to determine if the function would best be provided via a sharing arrangement between VA and LSU or independently owned and operated by both entities. The COPG's final report is to be presented by September 30, 2007.

VA'S FUTURE RELATIONSHIP WITH LSU

The VA remains excited about its MOU with LSU in the context of health care redesign in Louisiana. We support all of the principles behind it. At the same time, health care redesign seems to face some obstacles and delays in Louisiana. Because of this, we are committed to exercising due diligence to our veteran beneficiaries and to the tax payers, and are concurrently exploring other options for initiating reconstruction of the Southeast Louisiana Veterans Health Care System's medical center within Southeast Louisiana. In furtherance of this, we plan to begin a site search to identify alternative locations in the near future while we continue to work with LSU on our collaborative plans.

Mr. Chairman, we consider the committee and the Louisiana delegation to be partners with VA in seeing that southeast Louisiana veterans continue to receive the high quality health care that they have come to expect and deserve.

Congress appropriated to VA \$1.2 billion in supplemental funding for recovery and rebuilding efforts. This includes \$625 million to replace the New Orleans Medical Center. These efforts have enabled VA to provide timely access to care in New Orleans' surrounding communities through strategies such as leasing medical office space and establishing three new CBOCs.

The commitment to uncompromised excellence in health care and service to the community has resulted in bodies such as the Collaborative Opportunities Planning Group rethinking previously established relationships and identifying new strategies to improve operational efficiency and quality of care in areas such as academic medicine, use of electronic medical records, subspecialty care, and joint emergency preparedness planning. VA's construction of its new medical center will be an important part of improving healthcare services for veterans in New Orleans.

Thank you for the opportunity to be here today. I will be pleased to answer any questions you may have.

Questions for the Record

**The Honorable Ed Whitfield
Ranking Member**

**Subcommittee on Oversight and Investigations
House Committee on Energy and Commerce**

March 13, 2007

Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region

Question 1: Does the Veterans Administration continue to view the construction of a single campus with shared support services with LSU as the preferred option for a new VA hospital in New Orleans?

Response: Yes, the Department of Veterans Affairs (VA) continues to view the construction of a single campus with shared support services with Louisiana State University (LSU) as its preferred option.

Question 2: In your testimony, you state that health care redesign seems to face some obstacles and delays in Louisiana. What, specifically, are those obstacles and delays? Are these obstacles and delays what prompted the VA to begin exploring other options and searching to identify alternative locations or sites for the VA hospital?

Response: The principal delay has been with the State obtaining funds in order to acquire land for the campus. Although \$300 million in Community Development Block Grant Funds (CDBG) had been set aside for partial funding of Charity Hospital, the State has still yet to send and receive approval from the Department of Housing and Urban Development (HUD) for the use of those funds. Part of these funds is to be used to acquire land for the joint campus. This delay has prompted VA to begin concurrently exploring alternative land options.

Question 3: What does this exploration of new options indicate about your stated goal of restoring and supporting continuing medical education in New Orleans with both Tulane and LSU?

Response: VA remains steadfast in its commitment to supporting continued medical education in New Orleans with both Tulane and LSU and looks forward to perpetuating its long and successful history with its academic affiliates. As demonstrated at other VA campuses, this can be accomplished whether on the same or separate campuses.

The Honorable Charlie Melancon

Question 1: Mr. Lynch, did any member of the Louisiana delegation or their staff contact you or your department in regards to changing your testimony about your future relationship with LSU in the context of healthcare redesign in Louisiana?

Response: Yes, VA was contacted by a member of Congress.

Question 2: If so, who was this member and what correspondence between the relevant parties took place, as far as you know?

Response: Senator Vitter (via staff) asked the Department to consider different language for one paragraph of my statement. Since it did not fundamentally change the meaning of the paragraph, the proposed revision was adopted. Communication was by e-mail. Copies of the original and revised text are provided below.

Original Testimony
VA's Future Relationship With LSU

VA greatly values its affiliations with medical universities, medical schools, and public and private health care facilities and views this initiative with LSU as a unique opportunity to re-establish high quality health care for the veterans in southeast Louisiana, redefine VA's relationship with important affiliates, and assist in reinvigorating the health care environment in New Orleans. At the same time, VA recognizes that LSU is bound by the timelines of a complex process and directly impacted by the outcome of ongoing discussions at both the State and Federal level. Because of this, we are committed to exercising due diligence to our veteran beneficiaries and to the tax payers, and are concurrently exploring other options for initiating reconstruction of the Southeast Louisiana Veterans Health Care System's medical center. In furtherance of this, we plan to begin a site search to identify alternative locations in the near future while we continue to work with LSU on our collaborative plans.

Amended Statement

The VA remains excited about its MOU with LSU in the context of health care redesign in Louisiana. We support all of the principles behind it. At the same time, health care redesign seems to face some obstacles and delays in Louisiana. Because of this, we are committed to exercising due diligence to our veteran beneficiaries and to the tax payers, and are concurrently exploring other options for initiating reconstruction of the Southeast Louisiana Veterans Health Care System's medical center within Southeast Louisiana. In furtherance of this, we plan to begin a site search to identify alternative locations in the near future while we continue to work with LSU on our collaborative plans.

Question 3: We would like to formally request any and all correspondence between the aforementioned parties in regards to this subject.

Response: All correspondence regarding this matter took place in an exchange of email between VA and the office of Senator Vitter.

The Senator's office was provided with the draft provision regarding VA's future relationship with LSU. VA was asked to consider making minor modifications to that provision language. Because the requested text was merely one of emphasis and did not change the meaning of the original VA proposed text, the Secretary approved the modification.

TESTIMONY OF ALAN M. MILLER, PH.D, M.D.

Mr. Chairman and members of the committee: Thank you for the opportunity to speak to you all about the state of health care in the New Orleans region eighteen months after Katrina and about Tulane University's role in the recovery. Since Hurricane Katrina devastated our city—and our healthcare system—in August 2005, we've seen enormous progress in some areas despite almost overwhelming challenges. In other, critical areas, we have seen shockingly little progress resulting in a situation that now appears to pit the Federal Government against the State of Louisiana. Such an impasse will only make reform more difficult and the ensuing delays in the decision making process could threaten the very existence of our medical training programs. As you can see, we still have a long way to go before health care for the citizens of our region approaches anything near what we used to deem "normal."

First, I want to thank members of the committee for your support for the region over the last eighteen months. Many of you have been to New Orleans and have seen firsthand both the devastation and the progress. For those of you who have who have not yet been to the region, I urge you to come at your earliest opportunity. Through efforts such as this hearing and the spotlight it continues to shine on the challenges of our region, it is my hope we can move toward a system that provides equal access to quality care for all our citizens while also training a qualified and committed physician workforce that will assure the future of care in our State and region. At the end of the day, this is all about access to care for all our citizens, now and in the future.

My institution is somewhat different from those of my colleagues on this panel. I represent an institution of higher education whose mission includes not only providing healthcare to the citizens of the region but also training future physicians. Today, I'd like to focus my comments on four key areas:

- Tulane University's efforts in the immediate aftermath of the storm;
- Our continuing efforts to train the future physicians and provide clinical care;
- The immediate needs for retention of a qualified workforce; and,
- Long-term needs associated with maintaining and growing an adequate physician workforce to meet patient needs.

TULANE UNIVERSITY: AFTER THE STORM

The past year and a half has been extremely challenging for everyone in New Orleans, but especially for those of us trying to assess healthcare needs, rebuild a broken healthcare system, continue to provide care for all New Orleanians who need it, and continue to train young physicians. The Tulane University Health Sciences Center suffered losses of greater than \$200 million in property damage, lost research assets and lost revenue. Through the storm and since, despite seemingly overwhelming challenges Tulane—the largest employer in Orleans Parish—has continued to do exactly what it has done since its creation in 1834: providing health care, educating physicians, and advancing medical knowledge through research and discovery in New Orleans and Louisiana. Over the next few minutes I would like to update you on Tulane's current activities, our place in the recovery of health care in the New Orleans area, and our concerns for the future.

When Hurricane Katrina struck in August 2005 it left our 620 medical students, 520 residents and most of our faculty and staff scattered across the country. Our IT system was inoperable, all communications systems had failed and our student and personnel records were trapped in flooded buildings in New Orleans. At that point Tulane University consisted of 30 people working out of a Houston hotel suite.

What was accomplished in the weeks after Katrina is nothing short of remarkable. Faced with a self-imposed target date of September 26 to resume classes and training for our medical students and residents, in three short weeks of long workdays we set up a medical school at the Baylor College of Medicine with our displaced students using Tulane's curriculum and taught by Tulane faculty. We received critical life support from, and will always be indebted to, four Texas institutions that formed the South Texas Alliance of Academic Health Centers: Baylor College of Medicine, The University of Texas Medical School at Houston, Texas A&M University System Health Science Center College of Medicine and the University of Texas Medical Branch at Galveston.

At the same time, back in New Orleans, a small but determined group of physicians and residents remained steadfast in their mission to provide care to those who remained in our devastated city—both citizens and first-responders. Tulane University provided care at six sites, 7 days a week in Orleans Parish, seeing approxi-

mately 500 patients per day and becoming the largest ambulatory care provider in the parish. In October 2005, Tulane faculty and residents began to concentrate activities at Covenant House on Rampart Street. Since that time, more than 8,000 adult patients have been seen and currently 45 patients a day are being cared for. A separate pediatric drop-in clinic at the same site has seen close to 1,500 babies, children and young adults. At the drop-in center annex, mental health services have been provided to more than 141 clients for 536 visits since July.

In addition, Tulane Pediatrics, in partnership with the Children's Health Fund, has operated a Mobile Medical Unit treating patients at a variety of locations in New Orleans and in St. Bernard Parish. Since January, 850 adults and 1,000 children have received primary care services from Tulane Pediatric and Med/Peds faculty and residents in the mobile unit.

TRAINING OUR FUTURE PHYSICIANS

Well-educated and trained physicians are essential elements in assuring access to quality healthcare services not only in New Orleans but throughout our country. Tulane's healthcare mission and medical education mission are intimately intertwined. Teaching faculty, supervising medical residents, provide a large portion of the care for most there. Today, a total of 327 Tulane residents and fellows are being trained in 40 programs, approximately 63 percent of the number being trained pre Katrina. Each year that Tulane and the other major medical school in New Orleans, LSU, train a reduced numbers of residents, will have long-term implications for the supply of physicians in Louisiana.

In the 2005–06 academic year Tulane and LSU required special waivers from the Centers for Medicare & Medicaid services (CMS) in order to allow their residents to continue their training in multiple hospitals throughout Louisiana as well as outside of the State. In order for this to occur, protracted negotiations between the medical schools, the hospitals and CMS occurred. In the event of another major disaster where major teaching hospitals may be forced to close, a better solution is needed to deal with the disruption in medical training. Despite the waivers granted by CMS, Tulane still absorbed unreimbursed costs of approximately \$3 million related to graduate medical education (GME) for the 2005–06 academic year. Even with reduced numbers of residents and redistribution of residents to new locations, we anticipate an additional loss of \$2 million for the current year. It is not a financial burden we are able to carry much longer.

In addition to GME costs, with the city's public hospitals down, the burden of care for the uninsured has been assumed by the city's private hospitals and private physicians. The State's Medicaid Disproportionate Share (DSH) payment system has historically been directed to the State's safety net hospital system. With the closure of the largest components of that system there was a major gap in funding the care of those patients. The Federal Government has taken steps to assist hospitals in the care of this patient population. In March 2006, CMS allocated \$384 million for the uncompensated care pool to help hospitals that were caring for the uninsured. While appreciated, these funds have not been sufficient to compensate hospitals, and none of these funds were allocated directly to physicians and other healthcare providers. Tulane faculty physicians will have provided \$6.8 million in uncompensated patient care between September 2005 and June 2007. Tulane University has been able to retain the majority of its physician faculty by guaranteeing salary through the end of June 2007—in effect, a private nonprofit educational institution has been using its dramatically impaired and limited financial resources to help underwrite healthcare in the State and help preserve the healthcare workforce. Having suffered losses of approximately \$500 million in Katrina—\$300 million in addition to the losses at the Health Sciences Center—Tulane cannot continue to do this and survive.

If we are to preserve the physician workforce both at our teaching institutions and in the general medical community, there needs to be immediate funding for providing care to our citizens. If this does not occur, New Orleans physicians will continue to abandon their practices and leave the community, and we will not be able to recruit replacements. Those that suffer will be the patients who cannot find adequate care. It has been calculated that approximately \$30 million per year is needed to provide basic reimbursement to physicians for uncompensated care. A mechanism to providing funding directly to providers must be considered in order to reimburse physicians for care provided in the past 18 months and for ongoing support of care.

Another important component of both the patient care and graduate medical education missions of our medical schools has been the New Orleans Veteran's Affairs Hospital (VA). Pre-Katrina, Tulane faculty physicians provided approximately 70 percent of the patient care at the VA and 100 resident physicians were on rotation

at that facility. Since Katrina the hospital has remained closed, with inpatients being sent to other VA facilities, predominantly out of State. Outpatient clinics have reopened and visits are up to 75 percent of the pre-storm numbers. Currently, the VA is supporting 26 Tulane residents who are involved in the outpatient care. In order to provide optimal care to Louisiana's veteran population, keep them close to home and to return another important piece to the medical education pie it is essential to re-establish a VA hospital in downtown New Orleans. It is critical for Veterans that this facility be easily accessible from main transportation arteries and to the Tulane and LSU training programs. The VA must also be proximal to the medical schools so that the highly skilled faculty of those schools are available to provide state-of-the-art care, and foster the training of the physician workforce that is so important to the long-term future of health care in the region. It is also important for the economic development of downtown New Orleans that the VA be part of the growth of the Biomedical District. Tulane has been an integral partner with the New Orleans VA and desires to remain such in the facility's re-establishment.

IMMEDIATE NEEDS: A STABLE PHYSICIAN WORKFORCE

According to the Louisiana Department of Health and Hospitals there were 617 primary-care physicians in New Orleans prior to Katrina. By April 2006, that number had dropped to 140, a decrease of 77 percent. In July 2006, Blue Cross Blue Shield of Louisiana reported a 51 percent reduction in the total number of physicians filing claims in Region I. nearly all of this reduction—96 percent—was from Orleans Parish. The loss of additional clinical faculty at Tulane as well as LSU will not only decrease the available current physician workforce, but reduces the clinical teaching faculty needed to teach the next generation of physicians for the region and the State.

In addition to laying the groundwork for the future, there must be an immediate focus on the future of our Graduate Medical Education programs. According to a report prepared by the healthcare redesign collaborative, "The medical workforce situation has quantifiably deteriorated, but it could get worse before it gets better unless the State's internal engine of physician supply is rebuilt and modified for the new demands of a redesigned healthcare system. That engine is graduate medical education (GME), a rich source of newly minted physicians in any State but particularly in Louisiana. Among the States, Louisiana ranked No. 2 in the number of its doctors having trained within the State, and No. 17 in retention of residents."

In a sense, this is a long-term issue, but it requires immediate attention. I would request that Congress consider a time-limited grant program that would provide incentives to encourage clinical faculty candidates to come to one of the teaching institutions in the Gulf Region. Recently, \$15 million was made available for recruitment and retention of primary-care physicians. The Louisiana Department of Health and Hospitals is currently working on the details of how those funds will be distributed. But those funds do not apply to highly trained specialists needed to staff academic medical centers and training programs and provide care and educate the future physician work force. We would request that additional funding be made available for recruitment of qualified clinical faculty to the region's institutions, including loan forgiveness, relocation and bridge funding to allow adequate time for physicians to establish a practice.

LONG-TERM NEEDS: RETHINKING GRADUATE MEDICAL EDUCATION & ESTABLISHING A STABLE HEALTHCARE SYSTEM

As stated earlier, the gridlock in which we now find ourselves is destructive in the short and long term for systems, hospitals, medical schools and most importantly the public we serve. The time has come for all parties to set aside their differences, share vital information and data and have an objective party lead constructive negotiations. As a partner in MCLNO and as a member of the administrative board with legislatively mandated fiduciary responsibility, Tulane would welcome direct involvement in the current business plan development process for the proposed new facility. To this point, we have not yet been asked to participate nor have we been privy to any information beyond what was presented in November, 2006.

The experience of Katrina revealed a major flaw in the way we fund Graduate Medical Education in this country, at least under the circumstances of a major disaster that results in the closure of teaching hospitals. The slots in which residents train are allocated to hospitals by CMS, and the reimbursement for the educational efforts of those residents is paid by CMS to those hospitals. In many cases, like those of Tulane and LSU, the responsibility for training those residents is held by major medical schools. To provide the optimal educational experience these medical schools will rotate residents through a variety of hospitals. In order to provide the

residents with a stable pay source the medical schools function as a common paymaster, paying the residents directly and receiving reimbursement from the hospitals.

When Katrina hit and MCLNO and other training hospitals closed, the medical schools were left with the responsibility of guaranteeing the resident training and payment of salaries, but it left us unable to seek reimbursement from closed hospitals. Other hospitals came to the fore and provided training opportunities, but in most cases were unable to provide payment to the medical schools, which continued to pay the salaries of all the residents. Temporary waivers were finally received from CMS that allowed the residents to continue their training, but these did not go far enough to protect the medical schools, and created a complex system of documentation on the already strained systems of the medical schools and the closed hospitals. To simply comply with the burdensome paperwork required, Tulane was forced to hire outside counsel to navigate the process and complete the documentation. Some look at residents as movable parts that can be rearranged to maximize CMS reimbursement. This is far from the truth, issues of program interrelationship, critical mass and quality of educational experience must be considered or accreditation will be at risk.

This system must be reviewed and revised before another disaster hits one of our nation's training institutions, be it flood, fire, earthquake or an act of terrorism. In Louisiana, medical schools must have greater flexibility and control over slots not being used by the parent hospitals due to full or partial closure. Current arrangements for the redistribution of closed or partially closed hospitals—unused slots require the hospital to enter into affiliation agreements annually with the “receiving” hospital, and then for the medical schools to reach financial agreements with those receiving hospitals to repay the resident costs of the school. This arrangement puts the resident, the medical school and the receiving hospital at risk if the “home” hospital changes those arrangements or fails to execute affiliation agreements. For the protection of all, but most critically that of the trainee, medical schools must have greater control over both training and funding when a disaster results in total or near total closure of a teaching hospital. We now face a system that is uncertain and the instability created by the absence of our traditional training sites requires that we reconsider how these slots are distributed and by whom.

Tulane University and all the groups represented here today have many challenges still to overcome. But with the support of the American people and through our public leaders such as those of you on this committee, we will recover. And through our recovery we will provide our citizens with the best possible health care and a highly trained and committed workforce that will be a cornerstone to the long-term revitalization of the city of New Orleans.

Specifically, we ask your consideration in taking the following actions:

We request this committee consider convening a hearing to specifically deal with the issues surrounding Graduate Medical Education and possible solutions to preserve the quality of our training programs in the State. In addition, Tulane would like to host a panel that would include representatives from the committee, area medical schools and hospitals, as well as CMS and the AAMC to re-evaluate how resident training, and payment is dealt with in a disaster or other circumstances when the home hospital is either completely or partially closed, disrupting the training of those residents.

Provide funding for reimbursement of physicians for providing care to the uninsured. It is estimated that \$30 million per year is needed.

Create funding to assist medical teaching institutions in the Gulf Coast region recruit qualified specialty teaching faculty to train the future physician workforce.

Support the re-establishment of the New Orleans VA Hospital in downtown New Orleans, in proximity to the medical schools to allow for optimal patient care, medical training, and economic development of the New Orleans Biomedical District.

While it is our job to create a healthcare system that will provide the citizens of New Orleans and the State of Louisiana with highest quality care, I would ask that you strongly encourage all of the parties to consider an objective party to lead us to consensus and that we mutually agree upon a deadline for making the broader decisions regarding moving forward. Once again, I thank you for allowing me to speak to members of this committee today. With your help, we will continue to bring health care in our city and region not just back to where it was, but into an even better future.

TESTIMONY OF GARY MULLER

Mr. Chairman and members of the committee:

Thank you for inviting me to testify on behalf of West Jefferson Medical Center. I am grateful that the committee has expressed a continued interest in the worsening state of the healthcare system in the New Orleans region. I also would like to take this opportunity to thank Co-Chair, Congressman Melancon, for your dedication and hard work on behalf of the people of Louisiana.

West Jefferson Medical Center, located 10 miles from downtown New Orleans, is a 451 bed community hospital and health system with programs and services across a complete continuum of care. West Jefferson was one of three hospitals that did not close after Hurricane Katrina and is now one of the eight safety net facilities serving all patients. Pre-Katrina we were projecting an \$8 million profit for 2005. When I testified before this committee last year we had incurred operating losses of \$30 million I come to you this time with a heavier burden of \$48 million in operating losses. To put it in health care terms, prior to the storm we were a healthy patient. Now we are critically ill.

Financial survival has become the top priority for WJMC and we have focused efforts to explore every regulatory or legislative mechanism that might assist us. The Post Katrina story is complex as we embrace challenges continually. Providers of all types are experiencing significant financial losses as we struggle to retain health care workers and deliver care.

Recruiting nurses and physicians has become a near impossibility and the supply and demand of the entire healthcare workforce has reached a crisis. Prior to Hurricane Katrina we spent a total of \$2 million annually on agency nurses. Currently, we are forced to spend \$1.1 million each month, which was \$13 million in 2006. It is extremely difficult to simply have a physician visit our city for the possibility of working here.

The region's labor and operating expenses have inflated dramatically without corresponding payment increases. Hospitals have also experienced a dramatic rise in uncompensated care. I would like the opportunity to discuss both of these issues with the committee.

Certain financial adjustments are necessary to maintain hospital operations in our area.

The 2007 wage index update that was effective as of October 2006 was based on wage data from Medicare cost reports that began during Federal fiscal year 2003. Thus, there is almost a three-year lag between the data being used to develop the wage index and the actual implementation of the wage index that incorporates the data. Under the CMS methodology for incorporating changes to the wage index, our wage index will not begin to reflect the changes that we have experienced in labor costs until October 2008. We just can't wait that long. I am requesting that you consider a special wage-index adjustment for hospitals in the affected area to help offset some of the losses attributable to the added cost of operating in the post Katrina environment.

WJMC is a public service district hospital and we are supportive of the CMS Medicaid Proposed Rule on Intergovernmental Transfers (IGTs) and Certified Public Expenditures (CPEs) issued on January 12, 2007. As we understand the proposed rule, CMS will require States to direct Federal funds back to governmentally operated healthcare providers. This certainly seems aligned with how the Federal Government intended these funds to be used in the first place. For WJMC, we believe this will result in equitable distribution of funds to our hospital.

West Jefferson Medical Center has worked closely with our Congressional Delegation to identify existing Federal legislation that could provide us financial relief. We worked diligently to offer language to the Stafford Act that would qualify hospitals as eligible recipients of the Community Disaster Loan Program. With the hard work of our entire delegation we were successful in securing that funding. That funding from CDL was vital for our hospital in the few months following the storm when we incurred substantial financial losses. Both the House and Senate appear to be on the verge of Floor action to permit the Forgiveness of CDL loans, which has been the practice pre-Katrina. I strongly ask for your support to forgive these loans our hospital is currently obligated to pay back.

Please be reassured that we have taken all steps possible to become more cost-effective and efficient in our day-to-day operations. We have implemented an Operations Improvement Action Plan (OIAP) whereby approximately \$8 million of savings or revenue enhancements have been identified. Most of the cost savings center on reducing agency nurse costs which included only two agency nurses pre-Katrina and grew to 92 agency nurses presently. We have also improved efficiencies (per length of stay and discharges) so that the emergency room can flow better with the increase in patient volumes. WJMC also supports two federally Qualified Health Centers (FQHC) in our service area to support the medical home model of delivering primary care in clinics rather than in our emergency room.

Let me take this opportunity to provide you with a snapshot of our ED situation. One day last week we were overwhelmed with 32 admissions waiting in our emergency department. Simply put, every available bed in our hospital was occupied and we had 32 admitted patients waiting on stretchers in the hallway of the emergency department. Our ambulances and paramedics routinely wait with these patients which takes them off of the streets to serve other patients in need. Unfortunately, this is quickly becoming the norm as there are simply not enough staffed beds in the New Orleans region to care for the volume of patients. We put a phone call into the Department of Health and Hospitals expressing this concern. The next day the secretary of the department, Dr. Fred Cerise, was at our hospital offering assistance and potential solutions. He has also been helpful with his support of the Uncompensated Care Cost pool that was developed at the State level to offset some of our growing indigent care costs. Nonetheless, the shortage of beds, particularly psychiatric and acute care beds, is at a critical point.

I remain optimistic that, as discouraging as our problems may seem, our issues will eventually be resolved by both private and public hospitals, community clinic providers, payors and government officials presenting a united solution in a new model that will improve care for all citizens of Louisiana. I have great faith that our Federal leaders will not abandon us. Together, we can make a difference. Thank you for your time and interest.

TESTIMONY OF EVANGELINE FRANKLIN, M.D.

I am Dr. Evangeline Franklin, Director of Clinical Services and Employee Health for the New Orleans Health Department. To Chairman and Congressman Bart Stupak, Ranking Member and Congressman Ed Whitfield and distinguished members and guests of the Subcommittee on Oversight and Investigations of the United States House of Representatives Committee on Energy and Commerce: Thank you for the opportunity to speak with you today about two health clinics that the New Orleans Department of Health recently held in the City of New Orleans. Mayor C. Ray Nagin and members of his administration have sought creative means of addressing our citizens critical healthcare needs as we work to recover from the tragedy of Hurricane Katrina and the subsequent flooding.

Today I would like to describe to you a city, indeed a region, which continues in health crisis despite the valiant efforts of our organizations. This crisis results from a combination of factors. The people of New Orleans face many challenges, such as the difficulty of returning to rebuild homes and businesses, the tendency to ignore chronic illness that these stressful distractions have caused or exacerbated, and the complexity of the processes to claim insurance proceeds or funds from the Louisiana Road Home Program, the state initiative to compensate homeowners for their losses in Hurricanes Katrina and Rita. All of these are complicated by a healthcare system that itself is damaged and under stress, further limiting the access to healthcare that even before Katrina was not ideal.

In the aftermath of Hurricane Katrina, the population of the uninsured in New Orleans has expanded from traditionally uninsured groups to include many who have experienced sudden loss of benefits. This includes individuals who were laid off from jobs due to the destruction of their place of employment or the loss of market or tax base. Many of these people returned New Orleans following the floods because of personal or business financial commitments or because they simply wanted to come home. The composition of our uninsured also includes persons who cannot speak English and those who cannot secure health insurance because of their migrant worker status or lack of the proper immigration documentation. Many of our uninsured are part of the working poor, who toil daily in their jobs but are not offered or cannot afford health insurance.

Hurricane Katrina and the subsequent flooding were responsible for the loss of much of the health care infrastructure, including hospitals, doctors, medical records and pharmacies. It also meant that many people lost their medications, dentures and eyeglasses. This, when coupled with the physical and psychological hazards of the devastation, has put patients who were previously stabilized at great risk.

In the past year, was assigned to coordinate two large scale healthcare events designed to provide medical, dental and optical services, and to assist in organizing follow-up. By helping patients regain some control of health problems, the healthcare community could better manage medical resources such as emergency room use and admission to hospitals.

Both of these 7-day events were highly successful. Thousands of patients were able to leave each outdoor event with a 30-day supply of needed prescriptions, as well as eyeglasses, dentures, immunizations, PAP tests and information about

where to obtain follow-up medical care. Unfortunately, this occurred only after they endured long lines, sometimes waiting all night in cold and rainy weather to be treated on a first-come, first served basis by volunteers from throughout the country and local professionals. Typically, capacity for each day was reached within an hour of opening the registration. As a result, many who needed care were unable to receive it and had to be turned away to be seen on another day or at other locations.

The first of these events was held in February 2006 at the Audubon Zoo, a location considered by the planning committee to be an oasis in the middle of destruction. Audubon Zoo made a significant contribution by allowing us access to their grounds to set up the clinic locations, by housing volunteers and by having their employees contribute their time for the seven-day event.

This event was an immediate success, in large part because of its location and accessibility to the many patients who did not have cars. Many came by bus or walked to the event. The zoo is located in an area of the City which was among the first to repopulate because of the lower level of damage.

Because of the magnitude of the catastrophe, very few safety net clinics and pharmacies were available to residents so soon after the storm. Many weary patients reported that they were unable to locate their doctors and did not know where to go to have their prescriptions filled. Others offered poignant stories about their inability to obtain needed care, medications and immunizations. Of 5,212 persons who received care at the Audubon event, 27 were transferred to local hospitals for emergency care. One of those was a revived cardiac arrest. This woman was having her cholesterol level tested during her visit to the Reach 2010 at the Heart of New Orleans facility when she had what later was determined to be a heart attack. While she was unable to obtain primary care, she could be cared for after having a life threatening event. She is currently doing well.

Others were not so fortunate. One gentleman was given a diagnosis of metastatic cancer. He had been told at one of the local private hospitals that he had to pay for his diagnostic tests before he could receive treatment. He did not have the required money and was refused treatment. Because Charity Hospital had not yet reopened, there was no public facility in the city that could provide cancer care. Further complicating his situation, this man could not speak English and had no transportation. Despite these difficulties, we arranged for this gentleman to go to another facility to receive care.

Many of the volunteers during the week remarked that they had never seen so many people who were so very sick. In all, 1,313 volunteers treated 5,212 patients during this seven-day event. In addition, prescriptions were filled at no charge and social services, including mental health, were made available for interested patients. Volunteers traveled to New Orleans at their own expense.

The second event was held a year later in conjunction with Operation Blessing, a faith-based organization supported by the Christian Broadcasting Network. Operation Blessing operates a clinic with medical, dental and pharmaceutical services in eastern New Orleans. The weeklong Health Recovery Week II was took place in tents. The New Orleans East location of Operation Blessing was accessible by car and bus and had become an anchor by providing free care even before Health Recovery Week II.

This was an ideal location for the second event because the neighboring communities have shown signs of return and rebuilding. FEMA trailers placed in front of houses and the sale and purchase of property for renovation herald the return of significant resources of the professional and business community. In addition, citizens from eastern New Orleans were part of the regular patient population at Operation Blessing. Because the medical director is fluent in Spanish and Vietnamese, non-English speaking residents are drawn to this facility. In addition, this location does not interfere with the function of clinics and services in the part of New Orleans where the population has stabilized.

For this event, Operation Blessing invested nearly \$500,000 for the cost of supplies, lab work, pharmacy services, infrastructure improvement, marketing, and food and lodging for volunteers at their Slidell, Louisiana Command Center.

Even though more medical facilities and safety net clinics had opened in the intervening year, the story was exactly the same as before. Fewer patients were treated but only because there were fewer volunteers who could see them. Again, patients waited in the cold and the rain and were willing to be seen in tents for their medical, dental and optical care. And again, citizens frequently stated that they could not find their doctors and did not know where to get their medications.

The vast majority of patients seen during the health intervention week had never been to Operation Blessing. Many had been referred to obtain services that they could not receive in their regular clinics. Of the 3,800 patients seen at this seven-day event, 21 were transferred to local hospitals. As in the first Health Recovery

Week, hundreds were turned away after the capacity of the event filled within an hour of its opening. Among those transferred to the hospital, one patient was experiencing cardiac arrest and, like *deja vu*, a man with a terminal cancer told the story of being unable to obtain care. Many diabetics did not have their medications and many people were diagnosed for the first time with hypertension and diabetes. Women who needed preventive care, such as Pap tests, also were identified. The medical, dental and optical services provided were valued at \$1.1 million.

Again there were many non-English speaking patients who told of their fear of receiving health care because they might be identified for deportation.

These events highlight the urgency of our healthcare crisis in New Orleans and demonstrate that we need assistance to expand our capacity. When the Governors Emergency Order permitting health professional volunteers from out of state to practice in our city is lifted in the next few months, we will no longer be able to accommodate the medical, dental and optical volunteers who want to help and whose help we will still need.

Thank you for your consideration of what I have shared with you. These events and their large numbers indicate that the current solutions are insufficient to meet the needs of returning citizens and the new workforce. Our situation is urgent and we look forward to working with you.

TESTIMONY OF PATRICK J. QUINLAN, M.D.

Mr. Chairman, members of the subcommittee, thank you for this opportunity to appear before the Subcommittee to update you on the impact of Hurricane Katrina and its aftermath on the Ochsner Health System. First, I would like to thank the many Members of Congress, including members of this subcommittee, who have traveled to the Gulf Coast over the past 19 months to see for themselves the overwhelming devastation wrought on our City and our State as a result of the disasters associated with Hurricanes Katrina and Rita. Your personal presence and concerns are certainly appreciated by our citizens.

Ochsner Health System is an independent non-profit organization made up of seven hospitals and thirty-two clinics employing over 8,400 people. Ochsner is the largest private employer in Louisiana. Ochsner Medical Center was one of only three hospitals to keep its doors open despite the ongoing interruption of its business, during and after Katrina to care for all patients. We made this decision despite the fact that physical damage to our facilities caused us to suffer a significant interruption of our business both during and after the storm. Since Hurricane Katrina, Ochsner's professionals have quietly gone about their work of providing high quality healthcare to everyone—regardless of their ability to pay. We experienced significant physical damage to our facilities as a result of Hurricane Katrina. Ochsner has exercised due diligence to rebuild its property and mitigate the damage done to its business because of Hurricane Katrina. Nevertheless, we experienced significant additional costs and lost revenues as a result of this damage and the consequent interruption of business. The hospital also had to provide food and shelter for staff, as well as pay them for long hours at increased compensation. Ochsner's extensive disaster preparations played a major role in the ability to mitigate its damages, and to provide services for patients in the entire region under emergency conditions. That preparedness ultimately allowed citizens that evacuated to return home with the assurance that their healthcare needs could be met.

Hurricane Katrina caused property damage losses of approximately \$23 million to Ochsner facilities, but with the application of deductibles; only about \$11 million is covered by insurance. FEMA has paid a minimal amount to date. In addition, business interruption losses caused by Hurricane Katrina and its property damage have been over \$57 million. Our business interruption deductible, however, is approximately \$11 million. We continue to have issues with our primary insurer with resolving our claim. Total payments from insurance to date have been only about \$23 million.

Currently Ochsner employs over 600 physicians and more than 120 licensed mid-level health providers who receive no payment for the care of the uninsured. This acts as a significant drain for our Health System because of lack of funding for both hospital and Ochsner physicians.

We are one of the largest private non-university based academic institutions in the country with over 350 residents and fellows, proven research including bench research, translational research and clinical trials. In addition, we provide training for approximately 400 allied health students and over 700 medical students from LSU and Tulane with little funding to support this mission. The importance of Ochsner's graduate medical education program has increased greatly since Katrina

because we are the only fully functional academic center in the greater New Orleans area. We know that a significant number of physicians locate to practice where they train, so we are training the next generation of medical doctors for the area.

The sad reality is that we are bleeding red ink as a result of holding this fragile healthcare system and medical education system together and are caught in the middle of excessive bureaucracy in both the public and private sectors. Simply put, well-intended money to help us as providers is not reaching us on a timely basis. And when that money does reach us it is insufficient to meet our needs.

Despite our efforts at retention we lost over 2000 employees and more than 100 physicians during and after the storm who decided to leave the area. As a result we are currently experiencing a shortage of highly-trained physicians, nurses and support staff. Recruitment and retention continue to be a major issue. We are spending over \$20M annually in employment agency fees to staff critical areas throughout our hospitals. Wages have increased 10.65 percent as a result. While Health System wage costs increased almost 11 percent, the Medicare Wage Index decreased almost 4 percent. To attract the talent we need to continue to operate, the pressure to increase wages continues. A permanent fix to the Medicare Wage Index would be most helpful in addressing this issue as well as financial support to help in recruiting and retaining key personnel especially physicians and nurses. In October 2006 Ochsner Clinic was forced to increase physician salaries by \$6M or 5 percent above pre-Katrina levels to retain and recruit physicians to the New Orleans market. In addition, we are often forced to pay significant recruitment bonuses to attract the necessary staff.

Ochsner Health System also faces \$4.8 million in outstanding unemployment claims, which arose in conjunction with Executive Orders issued by the Governor that granted benefits to individuals unemployed as a result of the storm and suspended many of the normal requirements for obtaining unemployment benefits. While the Federal Government provided \$400 million in assistance to help pay for these claims, the Louisiana Department of Labor allocated all of the Federal relief funds to for-profit employers, leaving most non-profit and governmental employers that are self-insured to pay an enormous and potentially damaging amount of claims. In response, the Louisiana State Legislature enacted legislation that defers the payment of these claims until July 1, 2007 in an effort to identify solutions to the problem which could include an amendment to this Disaster Unemployment Assistance (DUA) Fund or an appropriation to the Louisiana Unemployment Trust Fund for the benefit of governmental and non-profit institutions from the Federal Unemployment Trust Fund.

Funding for uncompensated care is an issue for us. Ochsner has done more than its fair share of caring for the uninsured in the region. We have seen 24,731 uninsured patients since Hurricane Katrina at a cost of \$25.5M and we have been reimbursed only \$12.1M; that's less than 50 cents on the dollar for our costs. Please note that I am referring to our costs not charges and these refer to hospital services only and do not address our clinic load. With over one million clinic visits per year, the effects on the Institution are simply not understood by the traditional approaches of government at all levels. Our uninsured and Medicaid patient volumes have increased 50 percent from pre-Katrina levels. The time between providing care to the uninsured and receiving reimbursement has become excessive. We recommend that money for reimbursement for the care of the uninsured follow the patient directly and not go through multiple third parties to expedite funds reaching providers on a timely basis. Predictable funding is absolutely essential to predictable access for patients. And access is at the core of good medical care.

As part of its ongoing contributions to the recovery of the greater New Orleans region, Ochsner purchased three community hospitals in Orleans and Jefferson Parishes in October 2006 from Tenet Healthcare Corporation that were temporarily closed and significantly disabled in the aftermath of Katrina. These hospitals, as well as Ochsner Medical Center, require extensive disaster related infrastructure improvements at a cost of \$17.5M to retrofit and harden facilities in preparation for future storms. These essential preparations include raising transformers, relocating transfer switches, buying emergency generators, drilling additional wells and replacing flooded equipment.

We experienced significant additional costs and lost revenues. Extraordinary costs are included in all emergency situations as adjustments are made for the circumstances that develop. Volumes and related revenue are down but expenses are up significantly. There is precedent for the Federal Government to help in similar disasters. After the September 11, 2001 attacks on New York and Washington, aid was provided to hospitals for similar reasons. We ask for the same consideration today. We stepped up without reservation—we bet the company and ask for your help today.

Finally, more flexibility in the Health Resources and Services Administration grant process would be helpful in addressing some of the issues I have just described to you. Anything you can do to streamline the process as well as providing significant funds to address the shortfalls we have experienced would be most helpful.

We need your help if we are to survive long term as the largest healthcare provider in the State of Louisiana and to give us the ability to respond to future disasters successfully.

TESTIMONY OF KEVIN U. STEPHENS, SR., M.D., J.D.

I am Dr. Kevin U. Stephens, Director of the City of New Orleans Health Department. To Chairman Bart Stupak, Ranking Member Ed Whitfield, and distinguished members and guests of the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Energy and Commerce: Thank you for inviting me here today to speak on the state of healthcare in New Orleans. Mayor C. Ray Nagin and his administration welcome dialogue and are hopeful that this hearing will spur positive change as we work to not only rebuild our city's infrastructure and neighborhoods, but also to develop a state-of-the-art, modern healthcare system.

I would like to acknowledge and thank Secretary Michael Leavitt, represented on the panel by Leslie Norwalk, for all the support the Department of Health and Human Services has given to the City of New Orleans Health Department. Secretary Leavitt and I first met on August 24, 2005, less than one week before Hurricane Katrina, when we both visited the Ponchartraine Senior Center and talked with community leaders and senior citizens about Medicare. We developed a professional relationship which has continued in the aftermath of Hurricane Katrina. Additionally, I would like to thank Dr. Fred Cerise, Director of the Louisiana Department of Health and Hospitals, for his support to our city. Finally, I would like to acknowledge Dr. Robert Lynch of South Central Veterans Affairs Health Care. New Orleans has had a long relationship with the local Veteran's Affairs hospital, and we look forward to strengthening our partnership with it.

OUR HEALTH CHALLENGES

Louisiana has historically ranked among the country's lowest in health outcomes. For more than 10 years, Louisiana has been either 49th or 50th in state health rankings according to the United Health Foundation's America's Health: State Health Rankings. The report uses nine risk factors to support the rankings, such as the percentage of smokers in the State, and eight health outcomes, such as cancer deaths per 100,000 residents. In addition to the high risk factors in the state, citizens without the means to purchase private health care have suffered from a lack of medical resources and facilities, contributing to significant health problems. This highlights the necessity for a stronger, proactive local healthcare delivery system.

Charity Hospital has long been the primary source of healthcare for the indigent and uninsured in New Orleans. In 1992, Charity and University Hospitals merged to form the Medical Center of Louisiana at New Orleans (MCLNO). The complex developed a reputation as one of the best Level I Trauma Centers in the country—the only one along the Gulf Coast—and as an excellent training facility for health professionals. Many without private health insurance relied on its clinics as their main source for primary healthcare.

Recent severe budget cuts forced the MCLNO to close walk-in clinic, some operating rooms and some hospital beds. These cuts translated into decreased access to primary and preventive healthcare services for those who had few alternatives.

The City's 13 health clinics as well as other state and non-profit clinics also provided services to our citizens. However they lacked the capacity to meet the community's entire need for healthcare.

PROBLEMS EXACERBATED BY HURRICANE KATRINA

While the situation was dire, it was soon to reach crisis level. Hurricane Katrina, which struck on August 29, 2005, was the largest and most costly natural disaster in American history. More than 1,400 Louisiana residents lost their lives. Katrina also produced the first mandatory evacuation in New Orleans history, and the largest displacement of American citizens in U.S. history—1.3 million people. More than 200,000 New Orleanians remain displaced.

It is estimated that New Orleans sustained 57 percent of all the damage in Louisiana. Pre-Katrina, there were 215,000 housing units, 188,251 of which were occupied. More than 70 percent of the occupied units—134,344 units—sustained reportable damage, and 105,155 were severely damaged. Residential damage in New Orleans was \$14 billion. In addition, every hospital and medical facility in Orleans Parish was closed.

Since the storm and floods, only four of the eight hospitals in the parish have reopened, all at decreased capacity. The City's Health Department, which employed more than 200 health professionals, lost more than 60 percent of its staff and closed eight of its 13 clinics. Yet, as traumatic as this devastation was, it has given us a unique opportunity to redesign and rebuild a model healthcare delivery system that corrects the gaps and failures of the past.

New Orleans' population, which was more than 450,000 before Hurricane Katrina, is now estimated to be between 230,000 and 250,000 citizens. Even with the temporarily reduced population, approximately 20 percent of our citizens, more than 38,000 people, are uninsured. The City also has a rapidly increasing indigent worker population. Providing healthcare services to these uninsured citizens has placed a tremendous burden on the healthcare providers of the surrounding parishes and those in New Orleans that have reopened since the storm.

Another challenge has been the significant decrease in the number of healthcare providers in the parish. According to a 2006 Blue Cross/Blue Shield report, Orleans Parish had 2,038 physicians Pre-Katrina; only 510 physicians are on their network now. This 72 percent decrease highlights the relative loss of medical professionals in Orleans Parish. Other evidence can be found in a study conducted by the Louisiana Department of Health and Hospitals. Of 202 primary care physicians who responded to the survey, only 154 were still practicing and just 73 accepted patients dependent on Medicaid as their source of payment. Clearly, more providers are needed in Orleans Parish, particularly those who care for the uninsured and underinsured.

There is a similar story as it pertains to the capacity of Orleans Parish hospitals. According to a 2006 report from PriceWaterhouseCooper, New Orleans had 2,258 hospital beds before Katrina. According to a March 2007 report from the Metropolitan Hospital Association, Orleans Parish now has 625 staffed beds, a reduction of 75 percent.

Fortunately, neighboring Jefferson Parish lost far less of its capacity, with its number of hospital beds decreasing from 1,922 to 1,636. Jefferson Parish hospitals have been responsive in absorbing patients from Orleans Parish. But this does not negate the critical need for more hospital beds to open in Orleans Parish to meet the needs of our ever-increasing population.

It should be noted that many parts of this region which had the greatest impact from Katrina have no access to significant healthcare facilities. These areas include the Lower Ninth Ward and New Orleans East in Orleans Parish, as well as Chalmette and other parts of St. Bernard Parish.

The difficulty in obtaining services was highlighted by the number of citizens who attended Health Recovery Week II. Along with Operation Blessing, Remote Area Medical, the Mayo Clinic and International Medical Alliance, the City hosted the outdoor clinic providing medical, dental and optical services during the last week of January. In seven days, we provided free medical services to more than 3,800 citizens, but given the need, we could have served far more people. We opened at 6 a.m. daily and by 7 a.m., we were filled to capacity for the day. Many who received health care services had serious illnesses that were not being controlled and were life-threatening.

POST-KATRINA: CITY OF NEW ORLEANS HEALTH DEPARTMENT ROLE

The City of New Orleans Health Department must play a significant role in improving the health of the residents of our City. We need to fully staff our clinics and expand their offerings to include all preventative and primary care services. Since health outcomes are largely controlled by personal lifestyle choices, public health professionals must play a critical role in educating the public about health risks and behavior modification. These professionals also must ensure that we conduct the ongoing research necessary to understand our shifting healthcare climate.

EFFORTS TO REPAIR AND RENEW THE HEALTHCARE SYSTEM

Following Hurricane Katrina, the Bring New Orleans Back Commission, a group of City leaders convened by Mayor Nagin to design a comprehensive plan for the city's recovery, met to debate and decide on the future of the city's delivery of essential services to citizens. Commission members proposed policy recommendations for

the rebuilding of the city's healthcare system. Mayor Nagin approved the following recommendations:

Create an area-wide healthcare and human services collaborative that would develop a system of care for all segments of the population, provide primary care centers linked to hospitals and shift the focus of healthcare delivery away from institutional care toward ambulatory care and preventative medicine;

Develop comprehensive emergency preparedness plans for hospitals and collect the necessary resources to implement those plans;

Maintain a university teaching facility in New Orleans;

Empower all New Orleans citizens to play an active role in their access to healthcare services, i.e. promoting the usage of electronic medical records.

Once the commission made its recommendation, the city's needs became clear but we lacked the resources to implement them. In the spring of 2006, the One New Orleans Committee convened to discuss how we could effectively implement the recommendations of the Bring Back New Orleans Commission. The Healthcare subcommittee cited the need to lobby for state funds to assist private hospitals in the care of indigent and uninsured patients.

The subcommittee also identified the need to amend state policy to include reimbursements for uninsured patients permitting the healthcare dollars to follow the patient and not the institutions.

During the summer of 2006, the state led the Louisiana Health Redesign Collaborative (LHRDC), which was comprised of local and state stakeholders. Its key recommendations were:

- Develop a medical home model system of care
- Develop a health insurance connector
- Establish a Louisiana Healthcare Quality Forum
- Provide premium subsidy for uninsured children
- Expand coverage to pregnant women
- Give choice of coverage models, including private insurance
- Provide coverage for individuals with mental illness and addictive disorders

MENTAL HEALTH

The provision of mental health services poses a particular challenge in a region that has experienced severe loss, death and destruction. According to the 2006 Quality of Life Survey submitted by the University of New Orleans Survey Research Center, 20 percent or more of residents in both Orleans and Jefferson parishes are experiencing severe levels of stress and depression. This is not surprising given the obstacles our residents face in reestablishing their lives in a changed environment.

Despite this increased need, the city has fewer than 50 hospital beds for inpatient psychiatric care—about 17 percent of pre Katrina capacity. We estimate that only 20 of the 200 psychiatrists who were working in New Orleans before the storm have returned to continue their practices. The city has diligently collaborated with the LSU Health and Sciences Center Department of Psychiatry and the Metropolitan Human Services District to identify more mental health resources. New Orleans has an urgent need for more inpatient psychiatric beds, as well as new community mental health centers.

MORTALITY RATES

As a doctor and healthcare provider, I began to note a dramatic increase in the number of death notices in the newspaper since Hurricane Katrina. This observation was supported further by the deaths of two staff people in my own department within a short time and anecdotal accounts of families going to more funerals than ever. Due to the lack of current state data concerning this problem, the City's Health Department engaged in a study to count the death notices posted in the Times-Picayune newspaper and compared it to a parallel period before Hurricane Katrina.

In order to validate our methodology, we compared the number of death notices printed in the newspaper in 2002 and 2003 to the published state data from death certificates. In both cases, the difference between the two was not statistically significant. In 2003, we averaged 924 deaths per month according to death notices. In contrast, for the first six months in 2006, New Orleans averaged 1,317 death notices per month. This means that approximately 7,902 citizens expired in the first six months of 2006, as compared to approximately 5,544 in the first 6 months in 2003. These observations, as well as the severity of health problems treated during our Health Recovery Week, strongly suggest that our citizens are becoming sick and dying at a more accelerated rate than prior to Hurricane Katrina.

We believe these findings are significant, but the city has reached the limits of its ability to research this important issue. It is critical that state and federal agencies immediately study these trends as well as the causes of death. This information can then be used to develop appropriate interventions. We would also recommend that the federal government establish an electronic National Death Registry system to track mortality rates after any disaster that involves massive evacuation and mobilization of people across state lines. In the case of Hurricane Katrina, New Orleans residents were required to evacuate to more than 40 states.

Clearly, the healthcare system in New Orleans is far from normal, but we are working diligently to make improvements. The City of New Orleans Health Department has three proposals to comprehensively and systematically rebuild our healthcare system.

1. All citizens should have immediate access to primary, preventative and mental health care services. People are suffering now and we must respond.

2. New Orleans needs more hospital beds. The shortage of beds has reached crisis proportions, and on some days ambulances have to wait for hours on emergency room ramps to offload patients.

3. We must receive the resources to rebuild our city Health Department. Our Health Department is a necessary partner in the repair and reconstruction of the City's healthcare system.

Our healthcare system had serious inadequacies and gaps before Hurricane Katrina, but the storm ruptured it to a point that many more of our citizens are have lost access to healthcare services. Thank you for your attention to New Orleans. We look forward to working with you to solve these problems.

TESTIMONY OF DONALD R. SMITHBURG

Chairman Stupak, Ranking Member Whitfield, members of the subcommittee, I represent the LSU Health Care Services Division, which comprises most of the state public hospitals and clinics that have traditionally served as the public-teaching system in Louisiana. I must begin by expressing my sincere gratitude for the time and attention that you and your colleagues have devoted to understanding our plight in New Orleans and extending your support and assistance. Many members of this subcommittee, as well as a delegation led by Rep. Clyburn, took time out of their hectic schedules to travel to New Orleans to survey the suffering and devastation. These were fact-finding missions. They also were gestures of goodwill. But to those of us on the front lines of providing health care to the city's residents, these visits were much more. They reassured us that we will not have to go it alone and reinforced Congress' commitment to helping us stabilize and strengthen the health care delivery system. Today's hearing is one manifestation of that commitment. We are grateful for this opportunity and pledge to partner with you and with others testifying today to meet our obligations.

My testimony will briefly outline steps we have taken since Katrina to stand up some semblance of a health care delivery system. I then will add to the chorus of voices describing the current status of health care in New Orleans. In most respects, words are insufficient, but I will attempt to provide some clarity by concentrating on five key issues. I will offer suggestions for addressing the challenges we face in the short term. Some solutions require Federal action. Others simply require dialogue and partnership at the state and local levels. With oversight, guidance, and support from Congress, steps we take in the short term can provide a solid foundation for successful efforts well into the future.

INTERIM STEPS

Immediately after Katrina, LSU Health Care Services Division established limited clinic and urgent care services in tent hospitals created in partnership with the U.S. military and the U.S. Public Health Service. We operated a "Spirit of Charity" clinic in the vacated Lord and Taylor department store next to the SuperDome. In November 2006, we reopened part of University Hospital as the "LSU Interim Hospital." FEMA provided \$64 million in Federal funds for this renovation provided the facility would be operated on a temporary basis. The Interim Hospital offers all of the services that were available at Charity and University Hospitals before the storm, with the exception of psychiatry and inpatient rehabilitation. It has approximately 180 beds today "about 31 percent of its pre-storm capacity."

The Interim Hospital now operates 20 clinics in three buildings, which is in stark contrast to the 160 clinics that existed before Katrina. LSU plans to open seven

neighborhood clinics in the New Orleans area as soon as zoning variances are in place and the necessary permits are finally granted by the city.

With the destruction and closure of Charity, the region lost its only level I trauma center. For months, trauma patients had to be transported hundreds of miles away to Shreveport and Houston. LSU leased space at the suburban Elmwood facility and began providing trauma services there in April 2006. Those services were moved to the Interim Hospital in February 2007.

LSU has entered into a collaboration with the Department of Veterans Affairs for construction of joint facility to replace the neighboring LSU and VA hospitals that were destroyed. While this innovative and cost-saving project will not be realized for as long as five years, the partnership and the promise of a new, state-of-the-art academic health center does have a positive impact on helping us resolve some of our short-term challenges, such as attracting and retaining faculty and researchers.

FIVE KEY AREAS OF CONCERN

1. Medical education. Pre-Katrina statistics indicate that nearly 70 percent of practicing medical professionals in Louisiana completed all or part of their residency requirements at LSU and Tulane University. Prior to Katrina, the Medical Center of Louisiana at New Orleans (MCLNO) housed the anchor inpatient facilities for graduate medical education in Louisiana, hosting residency programs for both LSU and Tulane. LSU has temporarily repositioned its residency programs in other facilities throughout the state; however, this situation is inconsistent with the standards of ACGME and unattractive to academically superior medical students seeking residency slots in top-quality teaching hospitals. Thus, it is, at best, a temporary solution and is not sustainable in the long term.

Many of our training programs already are in jeopardy. LSU lost its radiology program, and this impacts other programs that require direct interaction with radiology for purposes of proper diagnosis and treatment. We are operating with a drastically reduced number of orthopedic surgeons. We have no trainees in oncology or rheumatology. LSU's urology and ENT programs are still relocated out of town. General surgeons are under increased strain because of the manpower shortages and the enormous trauma demands. Because the entities that accredit residency programs have certain volume and case complexity requirements which cannot be achieved when residents are dispersed among a multitude of smaller, private institutions, nearly all programs are in some degree of trouble.

Possible solutions to this crisis include:

- Commitment to a new academic health center which will restore a core facility requirement for both LSU and Tulane medical training programs;
- Authority to hire and obtain reimbursement for private physicians to alleviate the shortage of in-house academic medical faculty;
- Funding for recruitment and retention of students, residents, and faculty;
- A summit of all stakeholders in the medical education field in order to devise longer-term solutions.

2. REIMBURSEMENT

LSU safety net hospitals rely heavily on the Medicaid Disproportionate Share program. This source of revenues is critical to the system, but at the same time, CMS limitations on the use of funds for physician services and state-imposed disparities in the payment methodology for public and private providers diminishes our ability to fulfill our mission to provide care to the uninsured.

Unallowable Costs. CMS considers costs associated with payment of physicians and CRNAs to be "unallowable" under DSH. They are not regarded as "hospital" costs, and yet, like safety net systems across the nation, physician services in clinics are a critical component of service to the uninsured. This CMS policy is especially deleterious to the capacity to expand primary care and ultimately is more costly in terms of resulting inpatient utilization.

As a safety net system, especially one heavily involved in graduate medical education, LSU must support a massive base of physicians to provide care in the hospitals and clinics. The unreimbursable status of these major costs represents an exceedingly significant issue for any safety net health care system. For the LSU system of hospitals, which depends on the uncompensated care program for the uninsured or on direct state funding for nearly 60 percent of its revenues, the lack of a funding stream for physicians and CRNAs has created a gaping hole that must be filled by diverting revenues from reinvestment in infrastructure or by tapping short-term or one-time internal funding sources. The necessity of employing such

strategies has done significant long-term damage to our facilities and has diminished their capacity to perform their health care and medical education missions.

Disparity of Payment Methodologies. The Legislature limits the authorized Medicaid revenues of the LSU hospitals but does not limit the Medicaid revenues of any other individual public or private facilities.

State funds appropriated in the DHH Budget for state match for Medicaid hospital services are divided between the categories of “public” (10 state public hospitals) and “private” (approximately 120 nonstate hospitals).¹

Since the LSU hospitals are the only acute care facilities in the “public” group, they are effectively “capped” with respect to the amount of Medicaid revenues they can earn, and hence the amount of costs they can incur in delivering services to Medicaid patients.²

At the same time, individual community hospitals are not limited with respect to payments for any services they provide to Medicaid patients. While there is a fixed amount of state funding in the Department of Health and Hospitals budget for Medicaid match for the broad category of “private” hospitals, no maximum dollar amount of Medicaid revenues is communicated to nonstate facilities as it is to the LSU hospitals.

These differences have significant consequences as they play out in the operation of state and nonstate hospitals:

State Public Hospitals. The LSU hospitals in recent years have experienced a demand for services by Medicaid eligible patients at a level that has exceeded their appropriated Medicaid revenue limits. In this situation, if a hospital were to serve all the Medicaid patients projected to utilize it, the facility would incur costs that Medicaid would not reimburse once the cap were reached. Unlike community hospitals, the LSU hospitals do not have a sufficient base of patients with third party payers to whom they can shift unreimbursed costs, even if desired, and strategies are required to avoid incurring these costs at all.

Specifically, with an appropriated Medicaid revenue limit below the level of actual demand, administrators have faced the necessity of implementing early-in-the-year steps to reduce services to Medicaid eligibles.³

Control of the volume of Medicaid services, however, requires control of the volume of all services. Since it is not possible to target Medicaid patients only, such general steps as closing beds and curtailing clinic and Emergency Department hours are required. These actions do reduce Medicaid volume, but they also reduce the number of patients in all other payer categories as well. The result is (1) loss of revenues from other sources, (2) reduction of care to the uninsured, and (3) the reduction of service volumes upon which training programs depend.⁴

Nonstate Hospitals. Since the total appropriation to private facilities does not function as a cap on individual facilities, community hospital administrators are not faced with the same service adjustment decisions required of their LSU counterparts. Community hospital administrators can and do treat Medicaid as a payer source like private insurance that can be depended upon to pay the agreed upon rate for whatever volume of patients is encountered.⁵

¹ For fiscal year 2005 the appropriated amounts of state funds for public and private hospital categories for services to Medicaid recipients were approximately \$192.9 million and \$1.02 billion respectively.

² While the appropriation bill does not identify the maximum Medicaid revenues for individual LSU facilities, that detail is specified in effectively binding documentation associated with it and communicated by DHH, which manages the Medicaid budget.

³ In practice in some years, budget adjustments have been made through the year-end BA-7 process to increase Medicaid spending authority when the hospitals were generating Medicaid volume above the appropriated level. If this course of action were routinely followed, it would solve the problems described above, but it would also demonstrate that the cap was unnecessary in the first place. A BA-7 is optional, however. It cannot be presumed that matching funds will be available or that the legislature will agree to a budget change, and the hospitals must proceed to implement service reductions when faced with a projected Medicaid revenue shortfall.

⁴ The reduction in care available to the uninsured occurs as both a direct and indirect result of curtailing Medicaid revenues and services. The direct effect is through the general reductions in service to all patients, as indicated. In addition, however, an indirect effect on the uninsured results from the lost opportunity to spread overhead costs more broadly over a larger group of Medicaid patients. When such a payer class as Medicaid (and also Medicare and private insurance) is enlarged, there is less overhead that must be covered by the UCC payments for the uninsured. Consequently, a larger share of the total cost of services to these uninsured patients consists of payments for direct patient services. The implication of this is that to the extent that the state public hospitals can increase its mix of patients with third party payers, it can deliver more care to the uninsured with no additional cost to the state.

⁵ If the State were to face a mid-year budget problem necessitating cuts in Medicaid payments to private hospitals, it is possible to adjust the rates paid for services.

The practice of legislating separate limits on Medicaid payments to public and private hospitals—and especially requiring only the state hospitals to remain below an arbitrary cap—serves no good purpose for the State. It adds no assurance beyond the total appropriation of state funds for match to DHH that Medicaid program expenditures will be constrained within the appropriated level. In fact, since Medicaid is an entitlement program and a recipient unable to access the state public hospitals is free to utilize other providers, the public cap could increase per recipient costs as those with a Medicaid entitlement are driven away from the LSU hospitals and into higher cost systems for services.

Another Medicaid financing issue that could adversely impact our ability to fulfill our safety net mission is CMS' proposed Medicaid cost limit regulation. On January 18, 2007, CMS issued a proposed rule that would: 1) cap Medicaid reimbursement to public providers at the provider's cost of delivering Medicaid-covered services to eligible recipients; 2) greatly restrict the sources of state match funding through intergovernmental transfers (IGTs) and certified public expenditures (CPEs) obtain through public providers; and 3) require public providers to receive and retain the full amount of Medicaid payments earned. The rule adopts a more restrictive definition of "public provider" than what exists in current law. While the Administration contends that the rule would cut \$3.87 billion from the Medicaid program over five years, survey information from public hospitals across the country indicates that the initial impact will be far greater.

The fact that many nonstate hospitals that currently make IGTs would no longer be permitted to do so under the rule will leave a gaping hole in the State's Medicaid budget. This will lead to lower reimbursements and reductions in services.

As important as what the proposed rule specifies is what it leaves open-ended. The rule does not define "costs." There is a real threat that graduate medical education costs will not be included or allowed. This could mean a loss of more than \$50 million per year to LSU alone.

Possible solutions to these reimbursement problems include:

- Require CMS to allow public hospitals to claim physician and CRNA costs as allowable costs under DSH;
- Ask the administration to withdraw the proposed Medicaid regulation;
- Organize a "summit" on hospital reimbursement in Louisiana to develop equitable and realistic solutions that ensure proper reimbursement to all providers without destabilizing the safety net.

3. MENTAL HEALTH

There has been a significant loss of capacity in the mental health system as a result of Katrina. It is a system that already was under stress before the storm, and inpatients from the region, especially those without funding, were being transferred across the state to any available facility.

Post-Katrina, the city lost over 400 mental health beds—100 at our Charity Hospital facility and only about 40 of these have been restored in New Orleans. The Crisis Intervention unit at that public hospital was closed, along with all the services of the entire safety net facility.

The crisis we continue to face is manifested in multiple ways. At the clinical level, there is an exponential increase in mental illness. Emergency Departments have been impacted and are under strain because of the volume of patients whose symptoms require special handling, facilities, and expertise not currently available. A practice of rotation of behavioral health patients among EDs in both Orleans and Jefferson parishes has been implemented, and these patients and the type of care they require have contributed to ED overcrowding in the area. Emergency Departments were not designed to accommodate the special needs of these patients, and certainly not in the volume now experienced. According to one press report, police, who reportedly answer an average of 185 mental health calls each month, often are unable to find a hospital able and willing to accept mentally distressed citizens. They can and do book many of these mentally ill people into jail, but that does not guarantee proper treatment. One prison spokesperson reported that the jail spends \$10,000 to \$12,000 per month—21 percent of its total pharmaceutical budget—on psychiatric medicine. However, the jail has only one full-time, board-certified psychiatrist and two part-time psychiatrists to treat 2,000 inmates. It is no place to treat the seriously and persistently mentally ill. Just this past Thursday, a mentally ill patient who was roaming the New Orleans streets at night with a rusty BB gun was shot by a patrolling National Guardsman.

Potential solutions to the mental health crisis include: Funding to open additional inpatient mental health beds. LSU is working to establish 30–40 behavioral beds at a vacated hospital on a lease basis. Renovation of the space will be necessary,

as will support from FEMA. But more capacity is needed in the region. Funding for long-term care beds. More efficient use of short-term inpatient beds requires the ability to transfer appropriate patients to a long-term setting.

Funding for outpatient facilities. Improving the availability of outpatient services will provide alternatives to inpatient and ED admissions and overall reduce the stress on hospitals. Funding for telepsychiatry. This technology would enable the state to extend the reach of limited psychiatric resources. Incentives and funding for recruitment and retention of mental health professionals. The cadre of mental health professionals was decimated by Katrina. Proper staffing is essential to restoring both inpatient and outpatient clinical capacity.

4. Primary care delivery system. Emergency Department overcrowding existed prior to Katrina, but it has been severely exacerbated post-Katrina, particularly in light of reduced primary care capacity. Many patients present to the ED for minor ailments that are more appropriately addressed in an outpatient primary care setting. This reliance on the ED stresses limited resources, is inefficient and costly, and does not provide the patient with a coordinated, holistic approach to care. A recent article in *The Times-Picayune* reported on the crisis in New Orleans EDs. Hospitals in Orleans and Jefferson parishes have run out of space in their emergency rooms and are lacking sufficient numbers of acute care beds. "There is not a bed available anywhere in the city," said Jack Finn, president of the Metropolitan Hospital Council. The waiting time in EDs is now seven to eight hours—approximately the time required to drive to Dallas or Atlanta. Patients remain inside ambulances or wait in hallways on gurneys until they can be seen. Physicians believe that lack of swift access to primary care is part of the problem.

Insufficient primary care capacity causes other patients to delay seeking care until their condition worsens and becomes severe and very expensive to treat. The likelihood of a poor outcome only increases.

LSU is committed to a model of health care delivery that emphasizes primary care clinics located closer to where patients live. Primary care clinics are well-positioned to encourage better patient access, facilitate care coordination, and provide patient education. In a multi-specialty clinic environment with a vigorous disease management program, it is much easier to consider and treat the patient in a holistic context. The popularity of the "Medical Home" concept for health care reform is based on an understanding of these principles. As envisioned by the Louisiana Health Care Redesign Collaborative, the Medical Home Model calls for improved communication, information exchange, and care coordination (guided by evidence-based protocols). Such a model holds significant promise for improving care, increasing patient satisfaction, and controlling costs.

LSU strongly endorses the Medical Home concept. LSU's chronic care and disease management initiatives are consistent with the model and have produced demonstrable results in reducing the incidence of care in expensive settings and improving quality. We must now expand and strengthen the network of community health centers and neighborhood clinics in New Orleans in order to build upon these successes and optimize the benefits of the Medical Home model of care.

LSU already has offered to devote resources to community clinics, including a mobile ophthalmology unit made possible by a \$300,000 donation from Pfizer and New York Hospital Association. AstraZeneca donated \$1 million for a telemedicine project to be located in clinics that will facilitate diagnosis and specialty consultations. CLIQ is a data repository that allows sharing of laboratory and radiology information and is in operation at MCLNO and in PATH clinics. We have offered to implement a clinic referral system that will assign patients presenting at our hospitals to a community clinic for primary care services and follow-up based on the patient's zip code. All of these efforts demonstrate our resolve to bolster primary care clinics and better integrate them into the state's health care delivery system. Contrary to some fears that may exist, we have absolutely no interest in driving community health centers and clinics out of business. There is no upside to such a shallow strategy. We firmly believe that our success in delivering quality health care is dependent upon a strong and vibrant network of community clinics. We pledge to do all we can to support primary care clinics in the state and continue a productive collaboration with the coalition in greater New Orleans that is evolving.

Obviously, the availability of additional funding is central to our ability to increase primary care capacity through community clinics and implement the Medical Home approach. Funding should be directed in the following areas:

Physician and other related medical services. As described in detail below, the Centers for Medicare and Medicaid Services (CMS) does not allow us to claim physician, certified registered nurse anesthetist, and other "non-hospital" costs under DSH. Rendering these very real and critical costs "unallowable" suppresses the ability of the safety net to provide the extent of timely clinic and other physician serv-

ices that a Medical Home model requires. It is not possible to both implement a Medical Home structure and go unpaid for some of the most basic services that patients require. If CMS is not willing to change its policy, additional funding is needed to compensate for these services.

Infrastructure. A significant expansion of the network of community health centers and clinics requires an infusion of funds to acquire the necessary zoning changes and permits, build new facilities, lease space where appropriate, and provide increased staffing levels.

Information technology. The Medical Home model requires the ability to share patient medical information throughout the health care network. Thus, funding to develop electronic medical records and ensure interoperability is essential.

5. WORKFORCE

There has been an exodus of physicians and other medical personnel from New Orleans post-Katrina. Physician specialists are in short supply, particularly orthopedists, neurosurgeons, ENTs, interventional and other radiologists, anesthesiologists, and ophthalmologists. We also are experiencing a shortage of registered nurses and medical laboratory technicians. According to Louisiana Department of Health and Hospitals officials, there are currently about 450 primary care physicians in the New Orleans area, down from about 1,500 prior to Katrina. There simply are not enough mental health professionals to meet the growing need. The nursing shortage is so severe that annual wage and benefit costs have topped \$120,000 in some cases. We also have had difficulty filling administrative/managerial slots, as well as openings for maintenance workers, electricians, and carpenters.

The reasons for the workforce shortage include hospital closures, the slow and uncertain recovery of the region, lack of affordable housing, and deficiencies in basic public services, such as schools and police protection. With the closure of Charity Hospital, medical faculty are being lured to academic health centers in other states, and this has had a serious adverse impact on our ability to attract and retain medical students and residents and maintain robust medical education programs.

Possible solutions include:

- State and Federal funding that will enable hospitals to offer financial incentives to meet workforce needs;
- Federal housing assistance; and
- Commitment to a new LSU academic health center. While this facility will not be built immediately, the political wrangling and attempts by some to halt the process are exacerbating an already uncertain environment that threatens to choke off supply of future medical professionals in the state. Widespread community support for a new facility will allay concerns and help all hospitals recruit physicians, nurses, and other medical staff.

CONCLUSION

As you know, our challenges are great. But they are not insurmountable as long as political infighting and self-interest are set aside in favor of the interests of patients. I think we all agree on the problems. Our task is to marshal the intellectual capital of the entire health care community in New Orleans to arrive at sensible solutions that transcend parochial interests. If we do that, we will be well on our way to recovery. However, we cannot accomplish our mission without additional Federal assistance in the form of increased funding and regulatory changes as outlined above. It is my hope that the interest, attention, and influence of this subcommittee can help facilitate a productive dialogue and produce positive change for the citizens of New Orleans.

ANSWER TO SUBMITTED QUESTION FROM MRS. BLACKBURN

1. Regarding the mental health crisis in New Orleans, you recommend a variety of funding options, such as funding for outpatient facilities and long-term care beds, to alleviate the crisis.

Who should pay for these additional beds and services? Federal and/or State government?

With the “brain drain” occurring in New Orleans, who will care for these patients once you have more beds?

Prior to Katrina, the Medical Center of Louisiana at New Orleans (MCLNO) operated 100 acute psychiatric beds on the Charity Hospital Campus. Charity is closed, and there currently are no psychiatric beds in the LSU interim facility, which is

partially open with 179 acute beds. There were just over 500 total beds at MCLNO prior to Katrina.

As indicated in testimony, LSU is working to open about 40 psychiatric beds in a vacated hospital on a leased basis. As temporary replacement beds, FEMA funding for necessary renovation will be requested.

Plans for the construction of a replacement hospital for MCLNO in conjunction with the Veterans Administration should address the need for acute psychiatric beds on a permanent basis. The Community Development Block Grant will partially fund the hospital, with the remainder provided by bonds and FEMA replacement funds. Ongoing operation of the psychiatric beds in a new hospital is anticipated to be supported by state and Federal Medicaid funding, by Medicare and by various private insurance sources.

Recruitment of psychiatrists and other professional staff is problematic today and will require both continued state and Federal efforts to encourage successful recruitment of health care professionals to the area and the rebuilding of New Orleans generally. Financial incentives, such as through the Greater New Orleans Health Service Corp which offers grants to physicians who return and practice for at least three years, will be critical to success.

Availability of psychiatrists and other specialists is a complicating issue over and above facility needs. It is impossible to determine the pace at which the "brain drain" problem in New Orleans will be resolved, but a solution must go hand-in-hand with other efforts to restore our health care system and community in general.

MCLNO is attempting to open seven primary care clinics in various areas of metro New Orleans. While we continue to await city enactment of its zoning variance ordinance, it is estimated that these clinics will support 52,000 to 70,000 patient visits annually. While the clinics will not be providing specialty psychiatric services, they clinics will be able to screen for such problems and direct care to settings other than the Emergency Room. Such enhancement of the primary care delivery system will be important in unclogging Emergency Rooms and making them more accessible for emergent problems of all types. It is important to maintain focus on repairing the health care system as a whole in order for it to effectively address various kinds of specialized care.

Testimony of Leslie D. Hirsch
President & CEO
Touro Infirmary, New Orleans, LA
Before the
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

March 13, 2007

Mr. Chairman and members of the subcommittee, thank you for inviting me to testify today and for continuing to keep New Orleans and post-Katrina healthcare a national priority. As President and CEO of Touro Infirmary, a private, not-for-profit and faith-based major teaching hospital located in New Orleans' Garden District, I have an intimate understanding of the healthcare concerns and needs of our region. I am here today to speak about a number of post-Katrina problems that continue to plague Touro and other hospitals in New Orleans, as well as the delivery of healthcare in our community generally. I will also propose several recommendations that we believe would facilitate our recovery.

Let me begin by saying thank you for your support of New Orleans in the eighteen months since Katrina devastated our city. We are grateful for the continued interest and efforts of Congress, the President, Secretary Leavitt and the many others who have visited the area frequently.

While appreciating the assistance that we have received to date, we are concerned that many parts of New Orleans remain devastated. It's very difficult to accept the fact that

Testimony of Leslie D. Hirsch, President & CEO, Touro Infirmary, New Orleans
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these areas are still devastated more than a year-and-a-half later, especially considering that this condition exists in the United States of America. We acknowledge that this situation involves all levels of government.

Katrina devastated healthcare delivery in New Orleans and the surrounding areas. Thousands of dedicated healthcare workers---physicians, nurses, administrators, other allied health professionals, support staff, and community volunteers--have worked tirelessly to rebuild healthcare post Katrina. Although a valiant effort is being made, we are fighting a losing battle every day. The delivery of healthcare in New Orleans is a much greater challenge today than it was in the first few months following the storm. Conditions have worsened and continue to do so as more individuals return to New Orleans and the demands on the healthcare system increase. Healthcare is a core requirement of the city's recovery and the current system is in jeopardy. Additional Federal support is desperately needed to help stabilize and improve the situation.

Since its founding 154 years ago, Touro Infirmary has endured and recovered from more than its share of obstacles, but it wasn't until Hurricane Katrina struck that Touro would confront the greatest challenge of all. For only the second time in its history, Touro Infirmary closed. On September 1, 2005 we were forced to evacuate 238 patients, as well as hundreds of staff and family members. We were very proud to be the first hospital to re-open in the city just twenty-seven days later and to play a critical role in New Orleans' recovery along with the other hospitals in Orleans and Jefferson Parishes that have also shouldered a great burden-- financial and otherwise.

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Touro's re-opening and the important role it has played as a safety-net provider has been accomplished at a huge financial cost. Since the storm, Touro has operated at a substantial deficit. Due to the current situation, the Touro Governing Board recently approved a deficit operating budget for 2007. We continue to erode our cash reserves at a rapid pace, and endure the impact of resulting changes in our bond and credit ratings. We are not alone. There have been a number of recent stories in the news media stating that hospitals in the New Orleans area are bleeding red ink post Katrina.

Pre-Katrina the New Orleans metro area was estimated to have between 4,000 and 5,000 hospital beds. As reported most recently in the Times Picayune (March 11, 2007) there are currently about 2000 beds in operation. The situation in Orleans Parish is particularly challenging, as the number of adult acute care beds in operation remains dangerously low at about 500 to serve a population estimated at 200,000. In addition to Touro Infirmary which is staffed for 280 beds, there are only two other full-service adult acute care hospitals in operation. These include Tulane and the recently re-opened University Hospital that is a part of the state's Charity System. Touro, Tulane and University are also the only adult hospitals in Orleans Parish operating emergency services. Touro continues to be the busiest hospital in Orleans Parish.

Post-Katrina there are a number of significant issues that have had a negative impact on the operation of hospitals in the New Orleans metro area and the healthcare delivery system generally. These include, but are not limited to:

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- The unprecedented amount of uncompensated care provided by area hospitals;
- The increase in percentage of uninsured population and lack of an effective system of healthcare for this population causing an excessive strain on, and inappropriate use of, emergency services;
- The steep rise in the cost of labor, excessive reliance on contract labor and shortage of an adequate supply of trained healthcare personnel;
- The significant increase in cost and subsidization by those hospitals that have expanded their support of graduate medical education;
- The dramatic rise in the cost of property and casualty insurance;
- The lack of adequate primary care, specialty care and preventive health care services; and
- The lack of an adequate number of in-patient psychiatric beds and the resulting impact on area hospitals' emergency services.

Uncompensated Care and the Uninsured

Nationally, the uninsured population has been reported at about 16%. Even prior to Katrina the percentage of the uninsured population in Louisiana and New Orleans significantly exceeded the national rate. Post Katrina this situation has worsened. Recent reports estimate the rate of uninsured in New Orleans ranges from 20.4% to 26.1% (LPHI). Louisiana continues to have one of the highest percentages of uninsured as well as those living below the poverty level. Not surprisingly, various published reports have identified Louisiana as ranking 49th or 50th with respect to the health status of its population. The lack of an adequate supply of primary and specialty

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care physicians and a coordinated system of care for the uninsured causes patients to seek treatment for minor illnesses in emergency rooms across the region. This has caused severe backlogs, overcrowding and excessive delays in treatment and significant financial losses for hospitals.

The sharp increase in uncompensated care is a financial strain on hospitals throughout the region. Since Hurricane Katrina devastated the New Orleans hospital system, an unprecedented amount of uncompensated care has been provided by the already challenged private and nonprofit healthcare providers in the region. Last year for the first time in Louisiana a charity care pool of \$120 million was established to help fund the cost of uncompensated care at community hospitals. While appreciating the creation of this pool it is a partial solution and only covers about 40% of the cost of treating the uninsured.

For example, Touro's charges for uncompensated care have skyrocketed from \$17 million pre-Katrina to \$41 million in 2006, an increase of 141%. Our Emergency Department has seen a dramatic increase in volume post-Katrina from approximately 20,000 visits per year to 30,000. Uninsured patients originating in Touro's Emergency Department are responsible for about 90% of Touro's uncompensated care. This is an unsustainable position for Touro. Other area hospitals are experiencing similar difficulties. Hospitals cannot survive without being compensated for the care they provide. It is an unfunded mandate that must be addressed.

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Cost of Labor and Contract Labor

Prior to Katrina, Louisiana was designated by the federal government as a health manpower shortage area. That designation continues today. However, the post-Katrina labor challenges, particularly in the New Orleans metro area has worsened significantly. Our area has experienced large increases in the cost of labor, as well as shortages of critical health care personnel needed to fill both direct patient care and support positions. It is noteworthy that the labor shortage is not just limited to healthcare. For example, fast food restaurants in New Orleans have offered sign on bonuses as high as \$6,000 as a way of luring new recruits from a limited labor pool.

The national nursing shortage is exacerbated in post-Katrina New Orleans where hospitals face a highly competitive healthcare market in terms of the availability, recruitment and retention of qualified staff. Post-Katrina, salary rates have risen significantly. The use of contract or agency labor, particularly with respect to registered nurses, is a large component of the labor shortage issue and hospitals' reliance on this type of staffing has grown exponentially. For Touro and others, this issue is of equal magnitude to that of uncompensated care in terms of having a negative impact on the financial viability of our hospitals.

Moderate use of temporary staffing services can be helpful in certain situations. However, we believe that the disproportionate dependence on post-Katrina contract labor has significantly increased hospital staffing costs. At the same time, hospitals are

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unable to commensurately raise their rates to commercial or governmental third party payers to offset these increased costs. At Touro, the total labor cost for each man-hour increased 20.4% from 2005 to 2006 (see Table 1). This increase was driven largely by the cost of temporary contract labor which increased nearly 500% from 2005 to 2006. Indeed, the annual cost of a full-time equivalent registered nurse provided via a temporary staffing agency is approximately \$50,000 higher than the cost of salary and benefits for an R.N. employed by the hospital. In 2006, 17% of Touro's labor cost was for contract labor and amounted to \$13.9 million (see Table 2).

Cost is only one side of the issue. There are a number of other issues associated with the excessive use of contract labor, not the least of which is continuity of patient care.

Graduate Medical Education (GME)

In the aftermath of Katrina, Touro and other local hospitals expanded their residency training programs to absorb as many resident physicians as possible, thereby supporting and protecting the future of graduate medical education in New Orleans. Touro increased its program from eighteen to fifty-two.

Our commitment to help secure the future of graduate medical education has been very costly because of a federal rule that does not permit full reimbursement in the first year. Instead costs must be averaged over a three-year period. In effect, hospitals expanding their GME programs are financially penalized during this initial period and must absorb these added costs. This rule clearly did not envision the hardship created by Katrina.

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While it is our understanding that CMS attempted to address this concern through a partial waiver to allow full costs for an initial period that ended on June 30, 2006, it denied a waiver of the three-year averaging rule beyond that date. As a result, hospitals that provided the needed increase in support to help protect the future of New Orleans' GME will be penalized financially for the next three years. At Touro, the incremental cost of increasing the number of residents from eighteen to fifty-two during the first three years is \$9 million. Of this amount, \$4.5 million is related to the three-year averaging requirement. Touro's subsidization of GME is a material part of our budget deficit this year and as a result we must re-evaluate our position on this issue.

Property and Casualty Insurance

Property and casualty insurance costs have skyrocketed in the aftermath of Katrina. Touro's cost has increased by 374% from under \$500,000 per year to \$2.2 million (see Table 3). At the same time our coverage has declined.

Additionally, we have taken a number of steps to harden our facilities to help Touro better prepare to withstand future disaster situations, thus increasing its reliability for serving the community in a time of need and reducing its exposure to significant financial losses and claims. These steps included the installation of a water-well and an upgraded emergency generator loop. We are appreciative of FEMA's approval of the water-well, but are very disappointed in their denial of the generator loop project even though we were led to believe that this project would meet FEMA's guidelines. We

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could not wait for FEMA to act and have completed this \$4 million project. We will appeal to FEMA to reconsider its decision and are hopeful for a successful outcome.

Recommendations

1. **Implement healthcare redesign:** The impasse that exists between the federal government and the State of Louisiana to develop an acceptable and workable model initiative to reform healthcare in Louisiana, and especially in the New Orleans Region One area, must be resolved immediately. The impasse with respect to this issue that also exists among various parties within the State of Louisiana must also be immediately resolved. It is critical that healthcare redesign must focus on drastically reducing the percentage of the uninsured population, strongly support primary and specialty care, as well as preventive services, provide participants with the freedom of choice to obtain healthcare services, and assure that funding "follows the patient" and is not institution specific. These steps would result in a drastic reduction in the inappropriate use of emergency rooms for primary care and an overall improvement in the health of the population ultimately at a lower cost. The goal should be to improve health status in the state by 50% within ten years. While healthcare redesign is critically needed, in the interim there are other actions that can be taken to help the situation now.
2. **Approve Cost-Based Reimbursement:** Implementing a cost-based reimbursement system for hospitals in hurricane affected parishes and

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particularly for hospitals located in the hardest hit area, Region One, for the next three years will help to address many of the issues identified. It can be implemented immediately in the interim until healthcare redesign is finalized. Treat our hospitals as "critical access hospitals" similar to the treatment given to hospitals located in rural areas.

3. **Approve a Medicare Wage Index Adjustment:** The Medicare Wage Index adjustment will not reflect the unusual market conditions in New Orleans until October 2009. Although we appreciate Secretary Leavitt's recent announcement of \$71.6 million dedicated to help offset the labor cost increases impacting hospitals in Louisiana, we do not believe that it will adequately cover the significant labor cost increases in New Orleans. Analyze the gap between this amount and the true need and make an adjustment immediately.
4. **Increase Funding for Uncompensated Care:** More federal assistance in treating the uninsured is needed. Consider providing special grants for those hospitals most affected by this issue.
5. **Approve Waivers for Graduate Medical Education:** The presence of graduate medical education and a strong health sciences infrastructure is critical to the long-term recovery of New Orleans. It is also an important source of new physicians who will replace some of those who have left the region post Katrina. Approve a waiver of the three-year averaging rule so that hospitals that have stepped up in support of graduate medical education during this time of need will not suffer adverse financial consequences. Approve additional family practice

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residency training slots to increase the supply of primary care physicians in New Orleans, and remove or waive administrative barriers to adding new programs.

- 6. Increase Access to Physical Rehabilitation Services:** Physical rehabilitation services, particularly for brain injury patients, are in short supply. At no cost to Medicare, rehabilitation hospitals could be permitted to change status to become rehabilitation units of general hospitals without the current one-year reduced payment penalty. To do so will add significant efficiencies, thereby permitting much better access to these vital services.

- 7. Approve Additional Funding To Increase Health Manpower:** Approve additional funding or revise existing federal programs to provide incentives for physicians, nurses and other key health care professionals to relocate to New Orleans for a three year period in exchange for grant support to pay for tuition. Designate New Orleans as an *underserved area* for this purpose. Provide hospitals with direct funding to provide similar incentives such as: physician practice guarantees, loan forgiveness, recruitment and retention bonuses, and housing subsidies. The \$15 million grant for the New Orleans area recently announced by Secretary Leavitt, while appreciated, is flawed because it restricts hospitals from directly participating and must be re-evaluated.

- 8. Deploy Federal Resources to Help Relieve Pressure on Area Emergency Rooms:** Post Katrina DMAT's (disaster medical assistance teams) were deployed to New Orleans. These teams provided some useful purpose in the immediate aftermath of the storm but left before the population returned. In view of the heavy demands now being placed on emergency rooms (ER) in the New

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Orleans metro area, particularly by uninsured patients using ER's for primary care DMAT's should be deployed. This would help to immediately alleviate the excessive delays in treatment and overcrowding that currently exists.

9. Approve Additional Funding to Offset Cost Increases in Insurance:

Property and casualty insurance costs in New Orleans have skyrocketed post-Katrina. Provide funding for the next three years through a special adjustment in the rate paid to New Orleans hospitals by Medicare.

Thank you again for the opportunity to be here today. I welcome any questions that you may have.

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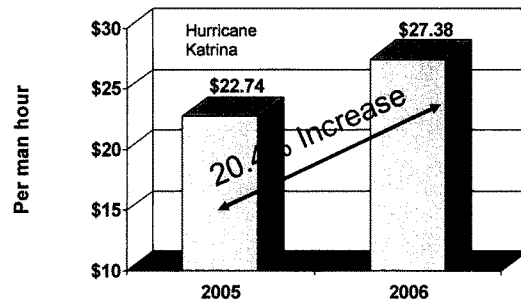
Appendix:

- Table 1 Labor Cost per Man Hour Paid
- Table 2 Contract Dollars
- Table 3 Property and Casualty Insurance Premiums

Testimony of Leslie D. Hirsch, President & CEO, Touro Infirmary, New Orleans
 Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region, March 13, 2007

Table 1

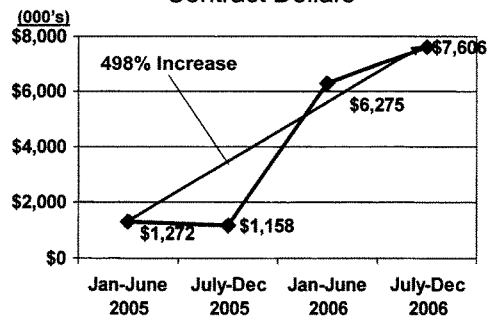
Labor Cost per Man Hour Paid
 (Touro Infirmary including Contract Labor)



SOURCE: Touro Financial Statements

Table 2

Contract Dollars

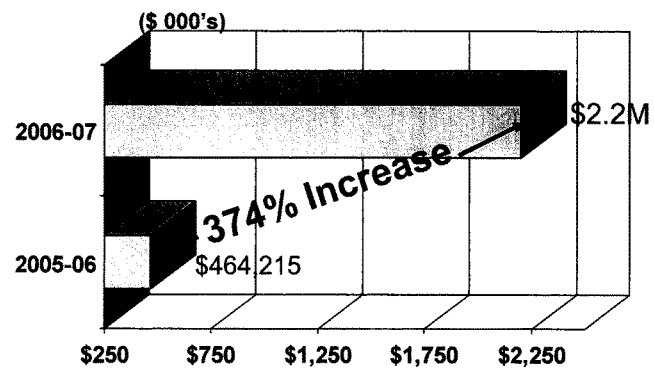


SOURCE: Touro Financial Statements

Testimony of Leslie D. Hirsch, President & CEO, Touro Infirmary, New Orleans
Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region, March 13, 2007

Table 3

Property and Casualty Insurance Premiums



SOURCE: Hartwig Moss Insurance

**Testimony of
Leslie V. Norwalk, Acting Administrator
Centers for Medicare and Medicaid Services
Before the
House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing on
“Post Katrina Health Care: Continuing Concerns and
Immediate Needs in the New Orleans Region”
March 13, 2007**

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss post-Katrina healthcare and the actions the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have taken to help rebuild the Louisiana healthcare system. Challenges continue but our commitment to address them has not waned.

On August 29, 2005, Hurricane Katrina struck the Gulf Coast just east of New Orleans, near Gulfport, Mississippi. The storm's impact was significantly increased by the failure of the Lake Pontchartrain levee around New Orleans on August 30th. On September 23, 2005, Hurricane Rita made landfall east of Port Arthur, Texas. The storms caused the evacuation of over 4 million people, destroyed tens of thousands of businesses, and over 100,000 homes, required the long-term relocation of over 685,000 families, destroyed at least 8 hospitals, and were responsible for the deaths of over 1,200 people. By comparison, the four Florida hurricanes of 2004 caused the long-term relocation of 20,000 people, and at the time, set a record for that statistic.

Immediate HHS Response to the Katrina Disaster

The public health and medical situation in greater New Orleans and throughout the Gulf Coast required substantial Federal resources to prevent even further loss of life. On August 31, 2005, HHS Secretary Mike Leavitt declared a Federal Public Health Emergency for the Gulf Coast

region. This declaration (together with declarations by FEMA under the Robert T. Stafford Disaster Relief and Emergency Assistance Act) authorized CMS to waive certain requirements for such programs as Medicare, Medicaid, and the State Children's Health Insurance Program. It also allowed HHS to make grants and enter into contracts more expeditiously.

Immediate public health and medical support challenges included the identification, triage, and treatment of acutely sick and injured patients; the management of chronic medical conditions in large numbers of evacuees with special healthcare needs; the assessment, communication, and mitigation of public health risks; mortuary support; and the provision of assistance to State and local health officials to quickly reestablish healthcare delivery systems and public health infrastructures. Federal departments and agencies worked together to attempt to meet these challenges, beginning before Hurricane Katrina's landfall and continuing long after.

HHS and Department of Defense health officials collaborated with State and local health officials, maintained situational awareness for their respective agencies, and hastened the direction of medical and public health assets. National Disaster Medical System (NDMS) teams also formed an integral component of the medical response to Hurricane Katrina, collectively treating over 100,000 patients. Several agencies assigned responsibilities in the National Response Plan (NRP) under Emergency Support Function (ESF)-8 (Public Health and Medical Services), sent liaisons to the HHS Operations Center in Washington, D.C. and the HHS Secretary's Emergency Response Teams (SERTs) in the affected States. The Department of Veterans Affairs (VA) used its extensive resources to deliver care to evacuees and veterans from the affected region.

HHS deployed medical supplies and personnel to bolster State and local public health capacity in the region. It provided pharmaceuticals and other medical supplies from the Strategic National Stockpile (SNS) beginning with pre-landfall deliveries to the Superdome. By September 3, HHS had delivered 100 tons of medical supplies from the SNS to Louisiana. HHS also deployed twenty-four public health teams that included epidemiology, food safety, sanitation, and toxicology experts.

Medical and public health assets provided excellent care to thousands of displaced patients with both acute injuries and with chronic medical conditions, many of whom had multiple complex medical requirements. According to the Governors from the Gulf Region, medical and public health professionals were the true heroes of the Hurricane Katrina response. They often had to improvise and use their own initiative because the system was slow to deploy them from staging areas or failed to adequately supply them. A member of an American Red Cross inspection team, Dr. Hilarie H. Cranmer, wrote, “[i]n a little over four days, our multidisciplinary and interagency teams assessed more than 200 shelters housing nearly 30,000 people. Amazingly, in a majority of cases, the basic public health needs were being met.”

Federal, State, local, private sector, and volunteer healthcare providers across the Gulf Coast took the initiative to overcome inefficiencies in the medical support system and meet their patients’ needs. Louisiana State University worked with the State Office of Emergency Preparedness, Federal personnel, and responders from outside the region to turn its Pete Maravich Assembly Center into an acute care medical facility. Within a week, the facility processed approximately 6,000 patients and more than a thousand prescriptions.

Medicare and Medicaid Waivers

On August 31, 2005, Secretary Leavitt invoked section 1135 of the Social Security Act, which provides for time-limited waiver authority during certain emergencies. Under this authority, CMS proceeded to waive or modify certain Medicare and Medicaid program requirements, deadlines and timetables for the performance of required activities to ensure that Gulf Coast residents and evacuees could get the care they needed. For example, conditions of participation, certification requirements, and pre-approval requirements were waived in certain cases and for certain providers. Sanctions and penalties arising from noncompliance with agreement to speak with family members or friends also were waived. All of these actions assisted providers and the scores of individuals urgently needing their care.

CMS quickly established multiple strategies to communicate with affected providers about the changes. For instance, CMS posted question and answer documents on the CMS website; held special "Open Door Forums;" and arranged meetings with the affected states, national and state provider associations, and individual providers.

CMS also established a special 1115 demonstration waiver program to help ensure continuity of healthcare services for the victims of Hurricane Katrina, allowing States to apply to be part of a unique cooperative demonstration. The 1115 demonstration program provided Medicaid coverage to affected individuals and evacuees from areas declared by FEMA as designated counties / parishes in Louisiana, Mississippi and Alabama. Individuals in affected areas or who were displaced by Hurricane Katrina could be temporarily enrolled in Medicaid through a

simplified enrollment process for up to five months. Under the program, individuals would be enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP) and receive benefits provided by the State hosting evacuees. States could choose to charge cost-sharing to evacuees. After the period of eligibility ended under this program, the individual would need to reapply and be determined eligible for Medicaid and/or SCHIP according to the eligibility standards of the state in which they were reapplying for benefits. The Deficit Reduction Act of 2005 (DRA) also provided CMS authority to pay the non-Federal share of regular Medicaid and SCHIP expenditures in FEMA designated parishes and counties. Finally, states also were able to request inclusion in a pool to reimburse providers who incurred uncompensated care costs for medically necessary services for Katrina evacuees without other health insurance coverage for such assistance.

As of January 31, 2006, CMS had granted a total of 32 states or territories Hurricane Katrina section 1115 demonstrations. Of those 32, eight states, which are in the immediate area to the devastated areas, were also approved for the Uncompensated Care Pool. States estimated that at least 325,000 evacuee participants would be served through the programs.

Grants and Other Funding to Help Louisiana Respond and Rebuild

HHS made available more than \$2.8 Billion in Katrina-related funding in Fiscal Year 2006 to help respond to the health-related needs of people affected by the disaster. This includes \$2 billion for federal payments to States for healthcare assistance; \$70 million in funding for healthcare related costs provided to CMS through a FEMA Interagency Agreement; a \$550 million Social Services Block Grant; a \$90 million Head Start hurricane-related Head Start

appropriation; and \$104 million in emergency Temporary Assistance for Needy Families (TANF) funding for states affected by the Hurricane.

Healthcare Assistance

The Deficit Reduction Act (DRA) appropriated \$2 billion for payments to eligible States for healthcare needs of individuals affected by Hurricane Katrina. To date, payments have been made to 32 states for a range of health-care related services and administrative costs for persons made eligible under the waivers, for uncompensated care costs, and for the State share of ongoing Medicaid and SCHIP costs for the affected areas in Louisiana, Mississippi, and Alabama.

Last month, using DRA appropriations, the Secretary also made available \$160 million to Louisiana, Mississippi and Alabama for payments to hospitals and skilled nursing facilities facing financial pressure because of changing wage rates not reflected in Medicare payment methodologies. Of this, 45 percent, or roughly \$71 million, went to Louisiana. In addition, on March 1st, CMS provided a \$15 million grant to Louisiana for professional healthcare workforce sustainability in the greater New Orleans area. These funds are for use in the four parishes that comprise Region 1, as defined by the Louisiana State Department of Health and Hospitals; namely, Orleans, Jefferson, St. Bernard, and Plaquemines parishes. The four parishes have been designated by the Secretary as Health Professional Shortage Areas.

Funding for Katrina and Rita Victim Aid for Uncompensated Care Costs

CMS received \$70 million in funding through a FEMA Interagency Agreement to support inpatient treatment provided to patients evacuated by the NDMS during Hurricanes Katrina and Rita, as well as for uncompensated care costs in four States with approved Uncompensated Care Pool waivers.

Social Services Block Grant

In FY 2006, the Social Services Block Grant received \$550 million in supplemental funds for relief efforts related to the 2005 Gulf Hurricanes. Funding was provided in varying levels to all fifty states, with the majority going to Louisiana (40 percent or \$221 million), Mississippi (23 percent or \$128 million), Texas (16 percent or \$88 million), Florida (10 percent or \$54 million) and Alabama (5 percent or \$28 million). These funds have been supporting initiatives to respond to human services and mental health needs of affected individuals. They also provide support to those lacking health insurance or adequate access to care, and to healthcare safety net providers.

Head Start

An additional \$90 million was appropriated for Head Start as part of the FY 2006 Department of Defense Appropriation Bill. This funding was to be used to cover the costs of replacing or repairing facilities that were damaged or destroyed by Hurricanes Katrina or Rita that are not covered by insurance or FEMA, and the costs of serving approximately 4,800 evacuee children from January 1, 2006 to the end of each grantee's 2006 school year.

TANF

The Administration on Children and Families (ACF) issued funds to the hurricane damaged states in the amount of \$69 million. ACF also awarded Katrina contingency funds to twenty states in the amount of \$36 million. The contingency funds were provided to States for short-term, non-recurrent cash benefits for families who traveled to another State from the disaster designated States who were not receiving TANF cash benefits from another State. More than 30,000 families were assisted through these contingency funds.

Rebuilding the Louisiana Healthcare Infrastructure

HHS and CMS have been fully committed to rebuilding the Louisiana healthcare system since Katrina hit the Gulf Coast. After the storm, Secretary Leavitt and senior CMS officials made several immediate trips to the area to meet with local and state healthcare leaders to hear concerns and suggestions, to see what the federal government could do, to help lessen the hardship, and to help rebuild an antiquated healthcare system.

The Secretary made the Louisiana rebuild effort one of HHS' top priorities for America's healthcare, and developed the HHS "Guiding Principles" to direct this initiative. Fundamental to those principles was a vision, developed with extensive input from local stakeholders, under which Louisiana's "two tiered" healthcare system would be transformed into a highly functioning, sustainable infrastructure that is capable of providing high quality care, in the right setting, when needed by the population.

The Guiding Principles include a commitment to assist locally led efforts to deliver quality care and preventative health services through existing mechanisms that support personal responsibility and choice rather than funding new Federal programs or State institutions. Secretary Leavitt personally led the way in providing this assistance, traveling to Louisiana eight times since early 2006, initiating communication with key State and local, private and public leaders in healthcare. These efforts helped to encourage and facilitate formation of the Louisiana Healthcare Redesign Collaborative (the Collaborative) that would develop and implement a practical blueprint for an evidence-based, quality-driven healthcare system in Louisiana. In addition, the Secretary committed to provide personnel and to make the Department's experts available to support the work of the Collaborative.

In July 2006 the State approved legislation establishing the Collaborative as an advisory board of healthcare stakeholders that would advise the Louisiana State Department of Health and Hospitals on healthcare policy and development throughout the State. HHS marshaled its resources and made them available in fulfillment of the Secretary's commitment to the Collaborative and its efforts. The Secretary brought on a senior healthcare executive to serve as advisor for the Louisiana healthcare redesign effort, and created a new HHS project office -- the Louisiana Healthcare Rebuilding Staff (LHRS) -- to enhance communication with the State of Louisiana and key stakeholders on his behalf, as well as to facilitate the Collaborative in the development of a effective and sustainable healthcare model for the State. This new office, consisting of ten CMS employees (including four senior advisors), served as the point of entry for requests, questions and technical assistance between HHS Operating Divisions (e.g., CMS) and the State of Louisiana on healthcare reform initiatives. Four members of the LHRS staff

were deployed to the Department of Health and Hospitals' Baton Rouge office in an effort to facilitate the work of the Collaborative and communication with the Department.

The LHRS Washington staff coordinated HHS Operating Divisions and Staff Divisions involved in response to requests made by the State or members of the Collaborative, including the deployment of technical subject matter experts, the review of a Concept Paper outlining the Collaborative's plan for rebuilding, and the review of the waiver and demonstration project to assure consistency and successful completion of the process.

The Washington-based LHRS staff made over 21 separate visits to Louisiana between July 2006 and February 2007 to assist in this effort. In addition, the staff provided the Collaborative with information on all federally-operated programs in the Gulf Coast that could impact the redesign work of the Collaborative as well as available programs that would meet the needs of the Collaborative requests.

On August 23, 2006, Secretary Leavitt visited Louisiana to meet with the Collaborative and local leaders to discuss next steps toward developing a blueprint for an evidence-based, quality-driven healthcare system for Greater New Orleans. Emphasizing the importance of making specific progress on reform concepts that could be the basis of the State's submission of comprehensive, budget neutral, Medicaid and Medicare demonstration projects, Secretary Leavitt challenged the Collaborative to organize three additional workgroups to review financing alternatives, the role of community health centers in providing patient-focused care, and the role of health information

technology. At that time, the Collaborative adopted an October 20, 2006 deadline to deliver its Concept Paper for reform to HHS.

Concept Paper

The Collaborative released its Concept Paper on October 20, 2006. Since that time, CMS has been working with the Collaborative to clarify certain elements of the proposal.

In response to the Concept Paper, Secretary Leavitt again traveled to Louisiana on January 31, 2007 and discussed a number of scenarios, consistent with the underlying principles of the Collaborative, that would be budget neutral to the federal government, affordable to the State, and expand access to insurance. These scenarios were not intended to propose a specific solution, but instead to illustrate that the State has great flexibility in structuring a demonstration. HHS is encouraging the State to use that flexibility to best serve Louisiana's needs.

Secretary Leavitt has pledged support for large-scale, budget neutral Medicare and Medicaid demonstrations to bring about the Collaborative's goals, provided that they are consistent with agreed upon principles for rebuilding. We will continue to engage the State in discussions over how the demonstrations and waivers might be structured.

Conclusion

Mr. Chairman and Members of the Subcommittee, Hurricane Katrina caused severe devastation. However, the network of compassion and caring demonstrated by federal, state, and local

officials, as well as healthcare providers and others was a profound and powerful manifestation of the greatness of this country.

Providers rushed to care for those in need without considering payments or program requirements. Providers, who were personally affected by the hurricane, as well as those in areas sheltering evacuees, have provided extensive medical services under the most challenging conditions. Our role is to support their best efforts to care for seniors, people with a disability, children and families with limited means, and anyone else who needs care and has nowhere else to turn. CMS and HHS have provided an array of financial and technical assistance to Louisiana and the entire Gulf Coast in the wake of Hurricanes Katrina and Rita. HHS encouraged the formulation of an unprecedented Collaborative of healthcare leaders, and provided resources to support the Collaborative's work and its mission. Secretary Leavitt has made a personal investment of focus and energy in rebuilding the Louisiana healthcare systems, supported by continuous technical expertise offered by CMS and senior officials throughout HHS. We will continue to make that expertise available, noting that ultimately, it is up to Louisiana to decide whether and to what extent they will pursue large-scale healthcare system reforms.

Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

**Summary of Testimony by Diane Rowland, Sc.D.
For Hearing on
Post Katrina Health Care:
Continuing Concerns and Immediate Needs in the New Orleans Region**

Before Katrina, Louisiana had a strained “two-tier” health system.

- A quarter of the population was below poverty and 20 percent were uninsured
- Health care for the poor and uninsured was provided through the state-run Charity hospital system financed by Medicaid DSH dollars
- More community-based care and broadened health coverage was needed

After Katrina, the New Orleans health system was devastated.

- Loss of health facilities and closure of Charity Hospital
- Dispersion of health care workers
- Confusion and disrupted care for people, especially the poor and uninsured

There has been slow progress in restoring health services.

- No streamlined way to provide emergency coverage under Medicaid
- Severe workforce shortages and limited hospital and clinic capacity
- Critical shortage of mental health services
- Growing uninsured population with new labor force
- On-going negotiations over how to rebuild and finance the health system

Steps could be taken in the short-term to help restore capacity and provide access to care.

- Maintain Medicaid and LaCHIP coverage for low-income children
- Expand coverage to reduce uncompensated care
- Provide incentive payments to rebuild workforce
- Develop additional community health centers
- Increase availability of psychiatric services

Adequate financing is necessary to support rebuilding efforts.

- Greater flexibility over access and use of already-allocated DSH funds
- Additional federal assistance

Introduction

Mr. Chairman and members of the Subcommittee, I want to thank you for your attention to the health care needs facing the residents of Louisiana and for the opportunity to testify today on what can be done to address the health care challenges in Louisiana in the aftermath of Hurricane Katrina. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. From 2004 to 2006, I served as a member of Louisiana's Health Care Reform Task Force charged with assessing how to improve health and long-term care services in Louisiana. Unfortunately, as we will hear today, Hurricane Katrina dramatically changed the planning and resources available for that effort.

The destruction and devastation in Katrina's aftermath was unparalleled in our nation's history. The path to recovery has been slow and the outcome uncertain. I am pleased the Subcommittee recognizes the importance of restoring health care services and is examining the efforts and progress in rebuilding health care coverage and capacity in New Orleans. I am honored to participate in this hearing today with so many local leaders and health care providers who have worked tirelessly to provide and improve health care services in Louisiana since Katrina struck and New Orleans flooded in 2005.

My comments today will draw on our studies and analysis of health care in Louisiana before and after Katrina to provide an overview of the health care system in New Orleans, assess

the impact of the storm on availability and access to health care services, and offer some perspectives on the progress and challenges of rebuilding the health care system in New Orleans.

Health Care in Louisiana Pre-Katrina

Hurricane Katrina devastated a health care system that was already straining to provide necessary health services to its population. Louisiana is one of the nation's poorest states and ranks at the bottom of all 50 states on most measures of the health of its residents. Louisiana had high rates of chronic diseases and ranked among the worst in the nation for infant mortality, AIDS cases, and diabetes mortality (Figure 1). Nearly one in four (23%) Louisiana residents lived in families with incomes below the federal poverty level (\$16,600 for a family of 3 in 2006), including nearly a third of Louisiana's children (Figure 2).

Low rates of job-based health coverage, coupled with the high rates of poverty and limited assistance for adults through public programs, left almost one in five non-elderly Louisiana residents without health coverage. The lower percentage of residents with employer-sponsored health coverage (56% vs. 61% nationally) was tied to the large numbers of small businesses in the state and employment in the tourism and service sectors, which have high turnover and low offer rates for health benefits (Figure 3).

Medicaid and the State Children's Health Insurance Program (SCHIP, called LaCHIP in Louisiana) covered about 20% of the population, but eligibility for parents and other adults lagged far behind that of children. Children in families with incomes below 200% of poverty

were eligible for coverage under Medicaid and LaCHIP, but income eligibility for working parents was limited to 20% of poverty or \$3,320 a year for a family of three (Figure 4). Adults without dependent children were ineligible for public coverage no matter how poor. Thus, while Medicaid and LaCHIP could potentially assist nearly half of all children in Louisiana, few adults qualified for coverage despite high levels of poverty. As a result, an estimated 750,000 Louisianians were uninsured in 2005.

Louisiana essentially had a “two-tier” health system, in which the insured population (including those with Medicare and Medicaid) had access to a range of community hospitals and physicians, while the poor and uninsured were mostly cared for through the LSU-run safety-net system of ten state-funded inpatient hospitals and a network of more than 350 clinics. For New Orleans, the “Charity System” was called the Medical Center of Louisiana at New Orleans (MCLNO), which included the iconic Charity Hospital (“Big Charity”), University Hospital, and affiliated clinics.

MCLNO served a largely poor, uninsured, and African-American population and accounted for 83% of inpatient and 88% of outpatient uncompensated care costs in the New Orleans area in 2003.¹ It was also the dominant provider of psychiatric, substance abuse, and HIV/AIDS care in the region, and housed the lion’s share of the region’s inpatient mental health beds. Further, Charity Hospital was home to the Gulf Coast’s only Level One trauma center and the busiest emergency department in the city, and it served as the major teaching hospital for both the Tulane and LSU medical schools. Additionally, with only two federally qualified health

¹ Rudowitz, R., Rowland, D. and A. Shartzter, “Health Care in New Orleans Before and After Hurricane Katrina,” *Health Affairs*, August 29, 2006.

centers in the New Orleans area, a lack of private providers willing to treat the uninsured, and the state's use of Medicaid disproportionate share hospital (DSH) funds to finance inpatient and outpatient care primarily at the state-run hospitals, the clinics at Charity Hospital were a dominant source of ambulatory care for the low income, providing 350,000 outpatient visits at more than 150 primary and specialty care clinics.² However, despite its substantial role, Charity Hospital was faced with shrinking public resources, a high burden of uncompensated care, and a lack of capital to make much-needed infrastructure improvements.

The two-tiered and institutionally based system of providing care to the uninsured in Louisiana was largely driven by the way in which it was financed. Medicaid represented not only a system of health care coverage for low-income people in Louisiana but also a mechanism of financing health care for the uninsured. Louisiana was a major user of Medicaid DSH funding; in 2005, Louisiana's \$1 billion in DSH funds accounted for nearly 20% of all Medicaid spending in the state (compared with about 6% nationwide).³ DSH payments are made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. In Louisiana, the state channeled most of its Medicaid DSH payments to the LSU system to finance care for the uninsured. Louisiana's use of Medicaid DSH funds in this way created a dependence on institutional hospital care for the poor, rather than outpatient or ambulatory care settings, because states generate DSH dollars through inpatient use. Using Medicaid to expand eligibility to the uninsured population would have allowed Medicaid funds to be directed toward

² Ibid.

³ Ibid.

more non-hospital-based care but would have eroded Medicaid funding to support the Charity Hospital system.

State and local policymakers were looking to reform the structure and financing of Louisiana's health care system even before Hurricane Katrina devastated the system. In March 2004, at the beginning of her administration, Governor Blanco convened a health care summit and then appointed a Task Force of state leaders and national experts to provide recommendations for reform. There was wide recognition that more extensive health coverage for the low-income population was needed, particularly for adults. Given the deterioration of the aging Charity Hospital, consideration was also given to whether a new facility should be built and the need to shift from a hospital-heavy model of care to greater use of ambulatory care located in the community. To this end, the state submitted a Medicaid waiver to the U.S. Department of Health and Human Services to use a portion of its DSH funding to finance coverage expansions and local initiatives providing access to primary and preventive care. This waiver was pending at the time Katrina struck.

Katrina's Devastation

As we all know, the damage wrought by Hurricane Katrina and the levee breeches on Louisiana is staggering—over 1,400 lives lost and 900,000 people displaced, 18,750 businesses destroyed, over 200,000 homes damaged or destroyed, and over 220,000 jobs lost.⁴ The immediate impact of Katrina on the health system was the destruction of health care services in New Orleans as hospitals flooded and patients were evacuated. Some on this panel remained in

⁴ Louisiana Recovery Authority, "Hurricane Katrina Anniversary Data for Louisiana," August 2006.

facilities where patients were unable to evacuate and heroically kept working amidst power outages and rising floodwaters, while others were in the Superdome delivering healthcare in the days after the storm. And then, they began the arduous process of restoring health services in their city.

Progress to restore health services has been slow. One year after the storm, only three of Orleans Parish's nine acute care hospitals were operational and at substantially reduced capacity. Charity Hospital, the center of the region's health care safety net, has remained shuttered since the days shortly after the storm. Some clinic services, however, were being provided in temporary facilities while University Hospital was being repaired. In neighboring Jefferson Parish, most hospitals, including Oschner and East and West Jefferson, continued to operate, helping to absorb some of the needs of people displaced from Orleans Parish, but were limited by staffing shortages and incurred large uncompensated care burdens.

The destruction of the health care system in New Orleans and the displacement of hundreds of thousands of individuals made it extremely difficult for people to obtain health care after the storm. The Kaiser Family Foundation conducted a series of structured interviews with Katrina survivors living in New Orleans, Baton Rouge, and Houston about six months after the storm to learn more about their health care experiences following the storm.⁵ These interviews revealed that although survivors often experienced health problems before Katrina, they were now facing even more daunting challenges in obtaining needed health care. Despite suffering emotional and mental trauma from the storm, with many experiencing anxiety, depression, and

⁵ Perry, M. et al, "Voices of the Storm: Health Experiences of Low-Income Katrina Survivors," Kaiser Family Foundation, August 2006, <http://www.kff.org/uninsured/7538.cfm>.

trouble sleeping and eating, almost none had received formal counseling services for themselves or their children.

Beyond these traumatic impacts, some survivors also experienced problems caring for the physical and mental health problems they had before the hurricane. A number of interviewees had been unable to obtain critically needed care or prescription drugs, even up to six months after the storm. Several bipolar and schizophrenic interviewees endured weeks without their prescriptions. Survivors expressed difficulty finding pharmacies, reconnecting with former providers or finding new ones, and paying for their care. Access to specialty care was particularly challenging; some pregnant women were unable to find prenatal care. Some attributed negative impacts on their or their children's physical or mental health to their lack of care. In the absence of care, some were trying to manage their conditions themselves—for example, trying to control diabetes through diet rather than insulin while living in a FEMA hotel without kitchen facilities.

Even those with private coverage or Medicaid faced challenges obtaining health care. Survivors in Baton Rouge and Houston had difficulty as a result of unfamiliarity with health resources in their new communities as well as lack of transportation. Those who returned to New Orleans had difficulty finding providers because of the loss of hospitals and providers and the closure of Charity Hospital—problems exacerbated by the overcrowding and long waits for care at the hospitals that continued to operate.

Health issues were further complicated by unstable living and financial situations, because some were having difficulty meeting their basic needs such as housing and food. Overall, how well people were faring reflected both their situation before the storm and their ability to connect with assistance after the storm. Unfortunately, some of the most vulnerable survivors who were interviewed, including elderly people, appeared to be disconnected from assistance. Separated from their family members and established support communities many were unable to get needed care and prescriptions.

Clearly, as they struggled to rebuild their lives and return home after Katrina, the people of New Orleans needed both to be able to access health care services for their ongoing medical needs and to receive assistance with new conditions and the emotional stress after the hurricane. Yet, the health services available to them were limited and difficult to access.

Progress and Challenges Since Katrina

The challenge of restoring health care services in New Orleans is magnified by the devastation to the overall health care system; the loss of numerous health care providers and staff; questions about the stability of state and local revenues; and the uncertainties around the size, composition, and timing of the population returning to New Orleans. A population survey sponsored by the federal Centers for Disease Control (CDC) and the Louisiana Department of

Health and Hospitals determined that less than half of Orleans Parish's population (191,139 versus 444,515 in 2004) had returned and was living in the city one year after the storm.⁶

Coverage Issues

Health care coverage provides the means for people to access health care services and financing to support the health care system. When Katrina struck, Louisiana already had one of the highest percentage of its population uninsured—20% statewide and 28% in New Orleans. Following Katrina, more people undoubtedly became uninsured as they lost their jobs and their health insurance. Some low-income Katrina survivors were able to turn to Medicaid for assistance, but because the eligibility standards for Louisiana Medicaid were not changed after the storm, many others were not able to access this coverage. For example, eligibility workers were forced to reject at least a third of all applications because they were for childless adults who did not meet the program's categorical eligibility requirements.⁷

There are no emergency provisions in Medicaid that provide flexibility to simplify the rules and extend Medicaid coverage with federal financing in a crisis situation such as this. After 9/11, Disaster Relief Medicaid in New York City provided a model for using Medicaid to provide immediate coverage by streamlining the process and the rules, but the federal response

⁶ "2006 Louisiana Health and Population Survey Report: Orleans Parish," January 17, 2007, conducted by Louisiana Public Health Institute on behalf of LRA, LA DHH, CDC, and the US Chamber of Commerce. Available at www.popest.org

⁷ Ross, D.C. and V. Wachino, "Medicaid Categorical Eligibility Rules are Providing a Major Obstacle to Getting Health Coverage to Impoverished Katrina Victims in Louisiana," September 2005.

to Katrina followed a different path.⁸ In September 2005, the U.S. Department of Health and Human Services set up special Medicaid waivers to allow low-income survivors from Louisiana, Mississippi, and Alabama to enroll in temporary Medicaid coverage in the states in which they were residing as long as they met the categorical eligibility requirements. Under these waivers, states could provide up to five months of Medicaid or SCHIP coverage to eligible groups of survivors and could also create an uncompensated care pool to reimburse providers for uncompensated care costs. The waivers did not allow states to expand coverage for adults without dependent children, regardless of income, and did not include any funding to support the temporary coverage or uncompensated care pools. Federal funding did not become available until the Congress authorized \$2 billion for the Medicaid coverage and uncompensated care pools nearly six months after the storm through the Deficit Reduction Act of 2005.

At the state level, Louisiana made attempts to try to maintain Medicaid coverage for as many enrollees as possible, including many who moved out of state. The Louisiana Department of Health and Hospitals delayed eligibility renewals until the end of 2006 and the state has allowed individuals who are out-of-state to continue to receive Louisiana Medicaid coverage if they indicate an intent to return. However, the difficulty of contacting beneficiaries—for many, the last known address was prior to Katrina and is no longer accurate—combined with enrollment losses related to increased documentation requirements passed in the DRA, has contributed to a Medicaid enrollment decrease of over 70,000 people statewide. Most dramatic was the change for Orleans Parish where 134,249 were covered by Medicaid on the eve of Katrina compared to only 59,023 Medicaid enrollees in Orleans parish as of January 2007.

⁸ Perry, M., "New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People," Kaiser Commission on Medicaid and the Uninsured in Collaboration with the United Hospital Fund, August 2002, <http://www.kff.org/medicaid/4062-index.cfm>.

Many of those who lost coverage are children, reflecting the movement of many families out of New Orleans. The state is planning an extended outreach effort for the spring to try to reach eligible individuals in the state who are not enrolled.

Caring for the uninsured is unlikely to abate as an issue for the New Orleans region. Many residents remain uninsured, and the problem is particularly acute for the low-income adult population. Though the unemployment rate in the New Orleans area has stabilized from its peak at almost 18% in September 2005 to just under 5% in December 2006, many are not offered health benefits at their current job.⁹ The influx of new workers, usually Hispanic, for construction jobs in rebuilding efforts will undoubtedly swell the uninsured population given the high uninsured levels among Hispanics, the low levels of job-based health insurance in the construction industry, and the prohibition on coverage of recent or undocumented immigrants in public programs. This, in turn, will put even greater pressure on the available health care services and uncompensated care funds. Further, providers will need to develop new language skills and cultural competencies to provide care to this population, which, historically, did not have a large presence in the New Orleans region.

Restoring Health Services

As of January 2007, the Brookings Institution's Katrina Index reported that only 52% of state-licensed hospital beds were in operation. Further, the number of physicians filing claims for medical services has fallen by roughly half, the number of safety-net community clinics in

⁹ Louisiana Department of Labor, Bureau of Labor Statistics. Reported in The Brookings Institution's *The Katrina Index*, February 2007, available at www.gnocdc.org

the region has dropped from 90 to 19, and a large share of the region's long-term care capacity remains destroyed.¹⁰ There are severe shortages in the health care workforce at all levels — physicians, nurses, attendants, laboratory technicians, dieticians, and housekeeping staff—that are essential to patient care, as many have relocated elsewhere in the state or out-of-state.

However, over the last 18 months, some progress in restoring health care capacity in the New Orleans area has slowly been made. After operating clinics out of tents in the Convention Center and then in an abandoned department store, LSU refurbished and reopened parts of University Hospital in November 2006, over a year after Katrina struck. Services are limited, but there is once again a 'Charity Hospital' presence in the city. This February, trauma care was transferred from a rented space at Elmwood Hospital to the reopened University Hospital. Once the University Hospital has been reopened and staffed, it is expected to have 140 staffed beds, considerably smaller than the former combination of Charity Hospital and University Hospital, but a resource for the poor and uninsured who continue to be a substantial share of the city's population.

A number of health clinics have also opened to help provide the community with primary and preventive health care. These clinics provide an invaluable source of care for returning residents who previously depended on the clinics at Charity for care, but are also increasingly becoming a source of care for the growing population of Hispanic workers and their families. Yet, enormous health care demands remain in the city, as evidenced by the thousands of individuals who attended the "Medical Recovery Week" health fair in late January to obtain free medical services, including dental care, vision and medical exams, and cardiology. According to

¹⁰ Rudowitz, R., Rowland, D., and A. Shartz, op. cit.

news reports, people began arriving as early as 2 a.m. to wait for the health fair to open and crowds gathered so quickly that those arriving after 8 a.m. were unable to get in. Clearly, many residents of New Orleans are going without basic care if so many wait in long lines at community health fairs.

Financing

Financing is a major stumbling block in the recovery efforts. As noted, prior to Katrina, health care for the uninsured was largely financed through DSH funds that were generated through patients' use of the state-run charity hospital system. When Katrina struck and both Big Charity and University Hospitals were closed, the state could no longer access these DSH dollars because the inpatient hospital care for Medicaid and uninsured patients on which DSH payments are based was gone. Because care of the uninsured was concentrated in the state-run charity system, only these facilities—and not the private hospitals—were designated by the state to be eligible for DSH payments. In order to reallocate DSH funds to private hospitals caring for the uninsured after the storm or community-based clinics or to use the funds for coverage expansions, the state needs a waiver from the federal government.

Restoration of health services and reform of the health care system thus remain major issues for Louisiana. The Louisiana Health Care Redesign Collaborative was formed in July 2006 by the state legislature and Department of Health and Hospitals to help guide the rebuilding process. A proposal emphasizing primary and preventive care, coverage expansions to a greater share of the population, health information technology, and evidence-based medicine was

submitted to the U.S. Department of Health and Human Services in October 2006. The ultimate outcome of these negotiations will shape the future of health coverage and services in the reformed Louisiana health care system. A key issue in these negotiations is whether the coverage provided will be publicly or privately sponsored and the future size and role of a public hospital replacing Charity Hospital versus distribution of low-income patients among the private hospitals. These decisions will shape how the dollars flow in the reformed health system.

Next Steps

While the debate over how to rebuild the health care system in New Orleans and what the appropriate mix of public versus private resources should be goes on, the people living in New Orleans continue to confront an inadequate health care system. In the fall of 2006, one year after Katrina struck, the Kaiser Family Foundation surveyed 1,504 individuals in Orleans, Jefferson, Plaquemines, and St. Bernard Parishes to assess their experiences one year after Katrina and learn more about their health needs.

Preliminary results from our Kaiser household interview survey to be released this spring underscore the public's concerns:

- 40% of respondents cited getting medical facilities and services up and running as one of their top priorities for the city, and a third of respondents felt there had been little or no progress in getting medical services and facilities back up;

- Nearly 4 in 10 (36%) were very worried that health services may not be available when they need them (and another 45% were somewhat worried);
- An overwhelming 88% said they did not think there were enough hospitals, clinics and medical facilities currently operating in New Orleans; and
- 88% said they did not think there were enough health services available for the uninsured in New Orleans.

When asked what should be done about health care services in New Orleans, the vast majority of respondents strongly favored reinvesting in the health care infrastructure and health coverage by rebuilding Charity Hospital, building more community-based clinics, and expanding public programs like Medicaid and LaCHIP to extend health coverage.

The perception of the people of New Orleans that progress in restoring health services has been slow and that more should be done to meet their health care needs mirrors the reality as one assesses both the progress and availability of care across the city. On site visits to medical facilities in the area, it has become clear that while very dedicated workers are trying tirelessly to piece back together the frayed health system, more needs to be done now to restore capacity and coverage. Long-range plans are fine, but immediate needs must also be addressed.

What steps can be taken now to help restore capacity and provide adequate access to health care services for the people of New Orleans? Among some of the options to consider are to:

- Maintain Medicaid and LaCHIP coverage for low-income children. Today, given the low incomes of families, a substantial number of children in New Orleans rely on Medicaid and the LaCHIP program. Maintaining that coverage will promote access to care for these children as well as provide payment to the clinics, doctors, and hospitals that treat them. Outreach efforts are also necessary to reach more children who are eligible but not enrolled in the program.
- Expand coverage to reduce uncompensated care. For low-income adults, Medicaid coverage is very limited. Extending coverage to at least the parents of the covered children through a Medicaid expansion would help promote their access to primary care, reduce uncompensated care costs, and support community based providers, whereas uncompensated care funds mainly assist institutional providers. The state would need to obtain a waiver to expand coverage for childless adults.
- Provide incentive payments to rebuild workforce. Restoring capacity is about more than bricks and mortar—it is about bringing back and retaining a health care workforce. Incentives for providers (physicians, nurses, therapists, etc.) are essential for recruitment back to a city that is still struggling with housing, schools, crime, and uncertainty. Having an

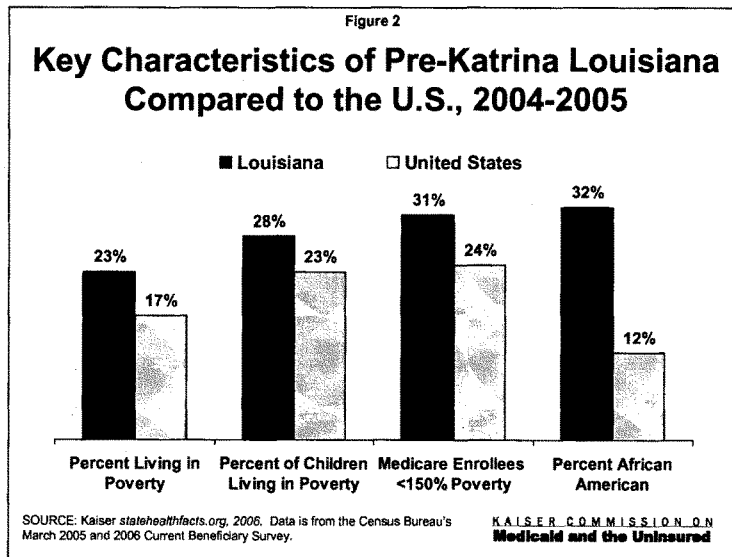
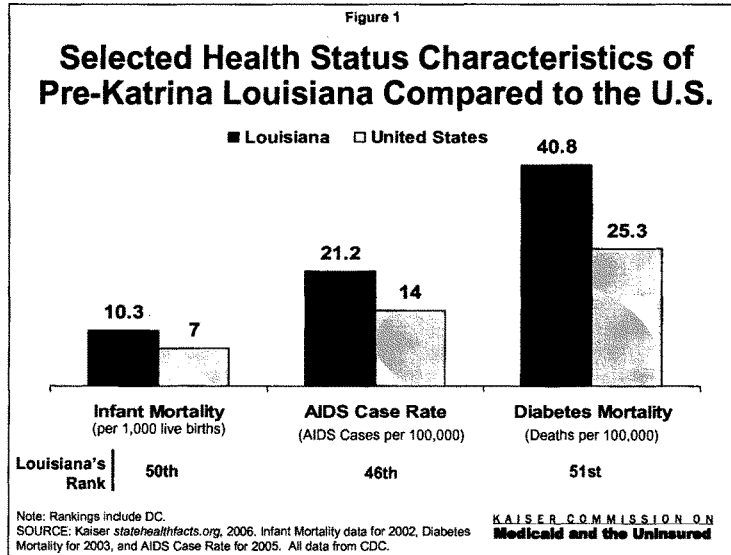
“incentive payment pool” could both provide recruitment bonuses but also help provide setup and capital financing as medical practices are being re-established.

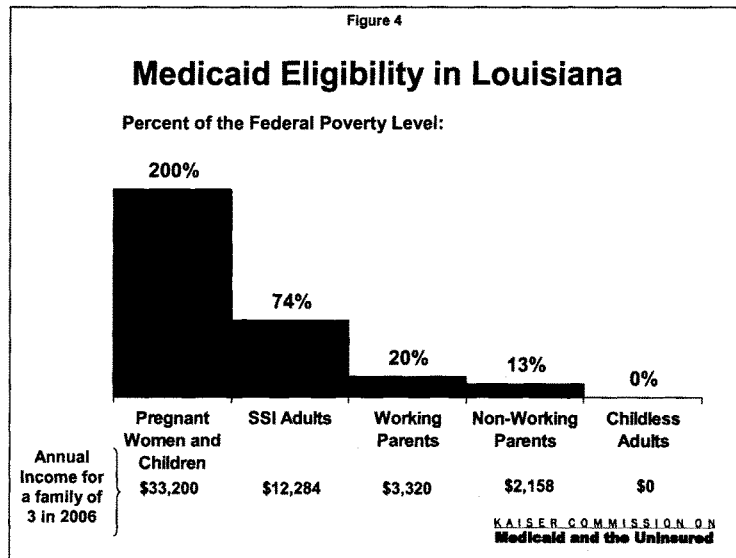
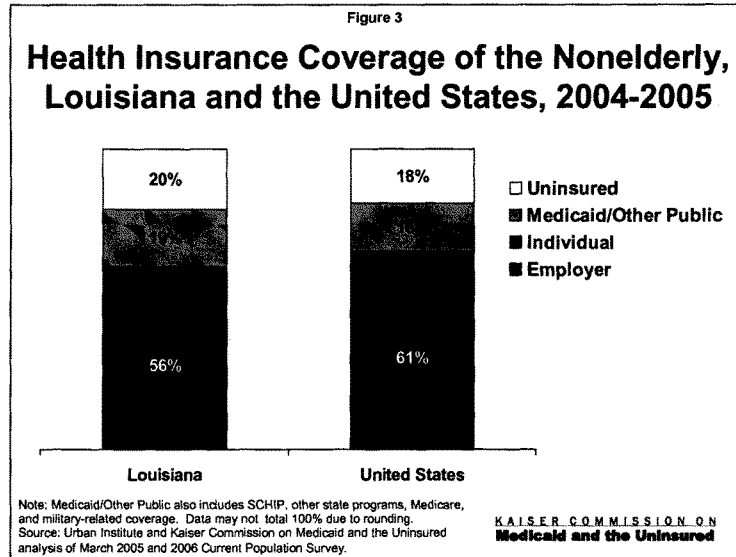
- Develop additional community-health centers. More primary care services throughout the community, and especially in neighborhoods that are being rebuilt, would both provide access to care for residents and a stable practice setting for returning doctors and health workers.
- Increase availability of psychiatric services. In addition to the mental stress from the devastation of Katrina, the city needs additional resources to deal with the chronically mentally ill. The shortage of psychiatric beds, the lack of community-based crisis centers, and the inadequate supply of mental health workers are critical needs. Extension of funding through the Social Services Block Grant in combination with workforce incentives and broadened Medicaid coverage of people with mental disabilities could help alleviate the shortages.

These steps are the kind of actions that could be taken in the short term to help restore health services for the community and ease the transition back to a rebuilt New Orleans. They would be building blocks to provide a solid foundation on which to build the “ideal reformed health system” for New Orleans that stakeholders are now debating. However, the ability to implement these steps is obviously related to the availability of adequate financing. Because of the destruction of Charity Hospital, the state is no longer able to draw down its full Medicaid DSH allotment, leading to a sharp reduction in available financial resources for the state’s health

care system. Giving the state greater flexibility over how it might access and use its DSH funds could help offset uncompensated care costs among private hospitals and community clinics and support efforts to expand Medicaid coverage, but is unlikely to be sufficient to rebuild Louisiana's health care workforce and system.

Thank you for the opportunity to testify today.





DIANE ROWLAND ANSWERS TO SUBMITTED QUESTIONS FROM MR. GREEN

Your testimony referred to the Disaster Relief Medicaid Program for New York after the tragedy of September 11, 2001, and how a different approach—the waiver process—was utilized to address Medicaid issues as a result of Hurricane Katrina. There is no question that the Federal response was more effective in New York, so I would like to explore why CMS did not build on that experience to respond more effectively to Katrina.

In your opinion, what factors contributed to the use of a waiver approach, and did you sense a lack of political will to respond in a manner similar to the response after the attacks of September 11, 2001?

Additionally, what legislative changes would you suggest we make to ensure that the Medicaid program can effectively respond to a disaster and provide real help to Americans during a public health emergency?

On September 19, 2001, 8 days after the terrorist attacks, New York Governor George Pataki announced a program called Disaster Relief Medicaid. The state had received Federal approval to implement a program to address the challenges Medicaid administrators faced as they attempted to operate with computer systems rendered defunct in the wake of the attacks. The program also addressed the health needs of New York residents by providing temporary Medicaid coverage beyond the scope of coverage available prior to September 11th. In the four months between the terrorist attacks and the end of January 2002, when New York's Disaster Relief Medicaid closed to new enrollees, over 350,000 New Yorkers signed up for the program.¹

Included in New York's Disaster Relief Medicaid were administrative simplifications that made it easier for New Yorkers to apply for coverage and expanded eligibility levels for Medicaid, particularly for adults. The state shifted from an eight-page Medicaid application to a single page and dramatically reduced the amount of documentation applicants were required to present. Eligibility interviews lasted about fifteen minutes and determinations were made on the spot, reflecting a change in procedure that appealed to low-income residents who could leave the interview with an assurance of immediate coverage.²

The state also increased eligibility levels for adults in New York City that had been approved but not put into operation as part of the state's Family Health Plus waiver in 1999, and it administratively implemented a New York Court of Appeals decision that required Medicaid to enroll all legal immigrants in the state, regardless of whether they arrived before or after 1996.

The State and Federal Government quickly partnered to implement New York's Disaster Relief Medicaid, putting in place within weeks a solution for those still grappling with the health and emotional aftershocks of the terrorist attacks. Simplified documentation requirements and application materials as well as expanded eligibility enabled more individuals to apply for and enroll in public coverage. An extensive outreach campaign, aided by private philanthropy and fed by the positive experiences applicants had with New York's Disaster Relief Medicaid, helped link vulnerable residents with health coverage and services.

In their September 2006 article in the *Journal of the American Medical Association*, Jeanne Lambrew and Donna Shalala reflect upon the Federal health policy response to Hurricane Katrina and provide suggestions to improve the Federal response to future disasters.³

To mitigate against future harmful delays in the Federal health response to disasters, Lambrew and Shalala recommend that Congress consider enacting a permanent emergency Medicaid authority that could build upon the program's existing eligibility and payment systems to address health coverage needs after disasters. Fully-funded, temporary expansions to broad or targeted groups could be triggered by legislative criteria or an executive agency designation. Lambrew and Shalala also point out that Congress and the executive branch can employ budget policy to appropriate funds for public health programs, such as through the Public Health and Social Services Emergency Fund. A reserve for use in disasters could be retained in this fund, which would revert to the Treasury if unspent.

¹ K. Haslanger, "Radical Simplification: Disaster Relief Medicaid in New York City," *Health Affairs* 22(1):252–8, January-February 2003.

² M. Perry, "New York's Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People," Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund, pub No. 4062, August 2002.

³ J. Lambrew and D. Shalala, "Federal Health Policy Response to Hurricane Katrina: What It Was and What It Could Have Been," *JAMA* 2006;296:1394–7.

In the face of the massive destruction to the Gulf Coast, and especially the New Orleans region, in the aftermath of Katrina there was no ready mechanism to extend coverage to the displaced, uninsured population and assist the providers trying to meet their health needs. Having emergency authority to extend Medicaid coverage and provide full Federal financing in disasters from a disaster reserve fund would provide an important safety net for the needy in times of crisis.

The witnesses on the hearing's second panel shared different views about the effect of CMS' proposed rule on Medicaid financing and limitations to cost. Given that the public hospital infrastructure has been crippled due to Hurricane Katrina and the private hospitals have taken on the bulk of uncompensated care, can you address the likely effect of this proposed rule on New Orleans' ability to shoulder uncompensated care costs?

This question seems to arise from Gary Muller's testimony stating: "as we understand the proposed rule, CMS will require states to direct Federal funds back to governmentally operated healthcare providers. This certainly seems to be aligned with how the Federal Government intended these funds to be used in the first place. For WJMC, we believe this will result in equitable distribution of funds to our hospital."

It seems that there is a misunderstanding about how the regulation would affect hospitals and providers and some confusion with this regulation and the way the state currently distributes Medicaid disproportionate share hospital payments (DSH). DSH is the primary mechanism used to support uncompensated care in Louisiana and the majority of Medicaid DSH funds are now targeted to the Charity Hospitals. This rule does not impact or affect the distribution of DSH payments.

The proposed rule would place new restrictions on reimbursement for government providers and limit the definition of a public hospital which restricts a states' ability to use intergovernmental transfers and certified public expenditures to fund their programs. The American Hospital Association, the National Association of Public Hospitals and the American Health Lawyers Association have all submitted comments to CMS to request that the rule not be implemented or significantly changed because of the impact of the regulations on safety-net providers and on how states fund their Medicaid programs. Ultimately, these changes could leave states with less funding available for safety-net providers which could further hinder efforts to support uncompensated care. Because Louisiana has in the past relied on intergovernmental financing arrangements to fund the charity system more heavily than other states, the proposed rule could have a larger impact on safety-net financing in Louisiana compared to other states. If the rule is implemented, it could also limit the state's ability to use similar financing arrangement with other public providers in considering options to restructure the health care delivery system.

For more specific comments about the regulation see the following:

<http://www.aha.org/aha/letter/2007/070315-cl-cms2258p.pdf>

<http://www.naph.org/naph/advocacy/NAPHCommentLetter.pdf>

<http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/AHLA—medicaid—IGT—030907.pdf>

STATEMENT OF DR. GARY WILTZ

Good Morning Mr. Chairman, and Members of the Committee – and it is a special honor today to appear before my Congressman, Mr. Melancon. Thank you for the opportunity to speak with you today about the very serious and continuing health consequences of Hurricane Katrina and its aftermath. I come before you this morning wearing many hats:

- First and foremost I am a practicing Board Certified Internist in a small rural community 100 miles southwest of New Orleans;
- I am also the CEO and Medical Director of Teche Action Clinic, a Federally Qualified Community Health Center, or FQHC, established in 1974, whose home base is located in Franklin, the seat of St Mary's Parish, with three satellites in Dulac, Houma, and Edgard;
- I serve as Chairman of the Governor's appointed Region 3 Health Care Consortium, which includes seven (7) rural parishes (Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne) all located immediately outside the New Orleans area (see map of Louisiana);
- I serve on the Board of Directors of the Louisiana Primary Care Association (LPCA), which represents the state's 21 FQHC's that together provide health care to more than 125,000 Louisianans – almost half of them uninsured – in nearly 50 communities throughout the state; and –
- I was just recently elected and now serve as national Secretary of the National Association of Community Health Centers, or NACHC – the national voice for America's community, migrant, and homeless health centers – known together as FQHCs – and the 16 million low-income Americans they serve in more than 5,000 communities across the country.

I would like to begin by telling you a little about my personal history. My roots run deep in New Orleans. I can trace my ancestry back for over 4 generations. I was born at Charity Hospital in 1953 on the ‘colored’ ward section of the then- segregated hospital. I grew up and attended the public school system in New Orleans, earned a scholarship to Tulane University, and later attended Tulane Medical School where I was fortunate enough to earn a National Health Service Corps (NHSC) scholarship while in medical school. Ironically, I did most of my residency training at the same institution where I was born, Big Charity in New Orleans. Upon completion of my residency, I was assigned to Teche Action Clinic in Franklin, to serve my 3 year service pay-back obligation; 25 years later, I am still practicing medicine at that same site. I gave you this history because it might help to shed light on how it shaped my perspective, as one who was born, raised, and educated in an urban setting, and who for the past quarter century has practiced in a rural environment.

In speaking of the health care realities in my home state today, I must begin by noting the sad reality that Louisiana’s health care system was broken pre-Katrina. Louisiana has the dubious distinction of having consistently ranked 49th or 50th among the states in the United Health Care Foundation’s annual health status report over the past 10 years. Our health care system has been fragmented, expensive, and ineffective, producing far too many poor health outcomes. Our system epitomizes the classic two-tiered levels of care: one for the “haves” – those with good health insurance that allows them access to all levels of care; and another for the “have-nots” – the uninsured, underinsured, and even most Medicaid recipients, who have at best limited access to only the most basic levels of care.

The original concept behind Charity Hospital was to demonstrate the compassion of the people of our state. It was perfectly named to fulfill its founding purpose – to provide “Charity”. The flag-ship of this system, located in New Orleans, fast became known affectionately among locals as “The Big Free”. Unfortunately, as we all know, nothing in life is truly free. Its urban location has left the state’s rural residents with no choice but to travel great distances to access this care. Pre-Katrina, the residents of the 7 rural parishes in our Consortium depended on Charity hospital – some for primary care and for most, specialty and sub-specialty care including mental health services. Katrina essentially destroyed the health infrastructure for the entire southeast part of Louisiana. It also decimated the healthcare workforce by displacing more than 6,000 healthcare professionals, most of whom have not returned. The true impact of Katrina’s devastation can not be understood or explained within a silo. Some summary points about Katrina’s aftermath:

- Southeastern Louisiana Healthcare Infrastructure Destroyed
- Healthcare workforce decimated
- Universities unable to provide training sites for medical students, residents, and other healthcare professionals
- Increase in numbers of individuals uninsured or underinsured who require/need health care, even as the overall population shrunk considerably
- Primary care providers no longer have access to a medical facility to refer uninsured patients requiring specialty and sub-specialty services

In the immediate aftermath of Katrina, our surrounding parishes saw evacuees overflowing into our communities. My family personally housed 19 family members for many months after the disaster hit. I am proud to say that Louisiana’s health centers

responded to this tragedy securing seven mobile units and dispatching them to emergency shelters and FEMA transitional housing sites to provide care to more than 200,000 evacuees at these sites. Moreover, our state Primary Care Association partnered with Morehouse College and IBM to provide training for over 160 healthcare providers on how to recognize and treat patients suffering from Post-Traumatic Stress Disorder (PTSD) and other behavioral health conditions. Our Association also secured assistance from the federal Health Resources and Services Administration (HRSA), from our National Association (NACHC), and from national and state foundations, to support the placement of 20 temporary medical providers at health centers across the state to provide life-saving health care, plus an additional 14 psychologists and licensed clinical social workers to respond to mental health disparities.

Now fast-forward 18 months and where are we today? To borrow a line from the play, *The Music Man*, “Oh, we’ve got troubles right here in river city.” Those of us who continue the struggle to provide care in the outlying parishes are seeing a number of serious health concerns that need immediate attention. In particular, we are seeing more and more patients suffering from depression, PTSD, suicide, substance abuse, acute psychosis, and domestic violence. In the wake of these ever-worsening mental health care needs, we face an enormous lack of mental health workers – particularly psychiatrists – as well as social workers and psychiatric nurse practitioners. There are no pediatric psychiatrists in our seven parish region. But our greatest problem is the lack of in-patient psychiatric services. We simply have no beds available for patients seeking detoxification treatments. Patients with acute psychiatric problems are having to be boarded in hospital emergency rooms. Those patients with dual diagnoses – those with

both medical and psychiatric health problems – have even fewer options. To underscore how serious these problems are, I give you several **true case studies**:

- A 38 year old male with a diagnosis of bi-polar disorder is brought to the hospital emergency room by a Sheriff's Deputy. Family members say that he has not seen a psychiatrist in 18 months because of Katrina. He is suicidal and homicidal, not for the first time – in fact, his last episode required in-patient treatment at Big Charity. A physician emergency commitment, or PEC, is completed, but he lacks health insurance – so we spend the next 10 hours attempting to find a facility willing to accept him, only to be told repeatedly “all beds are full with a waiting list.” He remains in the hospital emergency room for 72 hours, being sedated for his own and everyone else's protection, only to be finally released to his family when no other recourse can be found. In the succeeding month, he arrives several times at the same emergency room in the same condition, before a bed is miraculously found for him.
- Our regions only pediatric psychiatrist has left the area. The hundreds of children who were under his care are referred back to their primary care pediatricians' to manage their mental health issues. The pediatricians refuse to manage their psychotropic medications and refer them to the local psychiatric nurse practitioners (PNP). Our PNP alone has a two month waiting list so he is now seeing children who because this delay are now unmedicated and have now decompensated.
- A 57 year old female complains of chronic neck pain that is now worsening, with numbness in both arms and hands, associated weakness, and decreased motor

strength. She has Medicaid so an MRI can be obtained, which confirms that she needs neurosurgery; however, there are no private neurosurgeons who will accept Medicaid. Previously she would have been referred to Charity Hospital in New Orleans, 70 miles from her home town. Currently the only neurosurgeons accepting Medicaid are located at LSU charity hospital in Shreveport, a 6-hour drive from her home – if only she had transportation.

- A 40 year old resident of St John Parish, approximately 30 minutes from New Orleans, with a long history of hypertension and abnormal kidney function, urgently needs to be seen by a nephrologist. We are able to get him an appointment at Chabert Medical Center in Houma, about an hour away – but his wait time for the appointment is 3 months.

There have been numerous reports and other panelists will delineate the extent of the problem of people using the emergency room for basic primary medical care. This inappropriate use of these facilities has resulted in exorbitant costs.

So now that we see what the current landscape looks like, might I suggest some solutions? Let me say that, while the scope of the problems we face in our communities are so great that they will require the kind of money that only the federal government – or the state – can provide, the best solutions are not likely to be crafted out of Washington or Baton Rouge. Let me add one more point – that simply providing “health care insurance” to the many uninsured, while that is a crucial step to make health care affordable, will do little or nothing to make health care available or accessible, if there are no – or not enough – providers around to furnish that care. We need a model that

works, that is proven, that's cost effective, culturally competent and that can serve as a medical home – a health care home, in fact – and the beauty of it is that such a model already exists, in our nation's community health centers. This is not to suggest that they are the panacea to all our healthcare problems – but they certainly can play a large part in the solution.

Health centers bring good health to needy communities, and have compiled a remarkable record of achievement in providing care of superior quality, with exceptional cost-effectiveness and efficiency. Their costs of care rank among the lowest, and they reduce the need for more expensive in-patient and specialty care, saving billions for taxpayers and society. That helps to explain why the program has been ranked one of the 10 most effective federal programs by the Office of Management and Budget, and the top competitive grant program within HHS.

An expansion of health centers would quickly address the needs of the underserved across our nation, and be a critical step in transforming our health care system. Health centers improve the health of the patients and communities they serve by providing cost-effective, regular primary and preventive care that translates into reduced hospitalizations, lower use of emergency rooms, and fewer referrals to costly specialists, reducing overall health care spending significantly and producing far better health care outcomes. As a result, pressure on local emergency rooms will be lowered, saving tax payers significantly. Health centers are an excellent public investment that generates substantial benefits for patients, communities, insurers, and governments – indeed, for all of America.

Coupled with that is the need to expand support for the National Health Service Corps, the very program that brought me to my community in need a quarter century ago. Currently 3,900 Corps clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to nearly 5 million Americans in urban and rural communities with serious shortages of health care providers. About half of all NHSC providers are at health center sites – and we need many more of them today, and will need even more tomorrow.

In closing, I would like to quote some immortal words from Dr. Martin Luther King, Jr. that are as true today as they were on the day he spoke them, nearly 40 years ago:

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Thank you once again for this opportunity. I would be happy to answer any questions you might have.



Louisiana Primary Care
Association, Inc.



Louisiana's Health Centers Facts

- Louisiana's Health Centers collectively provide over 354,000 visits to over 125,000 patients annually.
- All Louisiana CHCs stimulate the local economy; are a proven model for quality, cost-effective care; and have excellent health outcomes.
- All Louisiana CHCs maintain intensive, state of the art quality improvement programs focused on population-based chronic disease conditions.
- Louisiana's communities that have CHCs have lower infant mortality rates than communities without CHCs. The CHCs provide appropriate primary care treatment, which in turn reduce inappropriate emergency room utilization and uncompensated care.
- Our Medicaid patients are 22% less likely to be hospitalized for conditions that can be treated in outpatient settings. Additionally, Medicaid patients who routinely use our CHCs cost 30% less than other patients.
- Louisiana CHCs are located in 28 of 64 Louisiana Parishes.
- According to the 2005 Uniform Data System (UDS) Report, 49% of FQHC users are uninsured, inclusive of Medicaid. Since Hurricane Katrina, the number of uninsured patients who received health care at Louisiana FQHCs has increased by an additional 15,541 uninsured evacuees.
- Total Users: 125,680
- Uninsured Users: 60,326 or 49%
- Total Encounters: 354,071
- Medical Health Service Users: 101,836 or 82%
- Mental Health Service Users: 5,222 or 4.2%
- Dental Health Service Users: 27,780 or 22%
- Average Total Cost Per Total User: \$372
- Average Charge Per Self-Pay Users: \$194.14 (Includes the uninsured)
- Sliding Fee Discounts : 66% of Self-Pay Users
- State Wide Weighted Average PPS Rate: ~\$120
- Total Full-Time Equivalents: 644

STATE POLICY RECOMMENDATIONS

Policy Request: Expand Health Care Services to an Additional 544,000 Louisianans through a Multi-year phased 179 Additional FQHC Sites Expansion Initiative

- LPCA is currently working with Capital Link, Inc., to develop a capital funding program for FQHCs that would leverage New Markets Tax Credit (NMTC) funding and the HRSA and USDA Loan Guarantee Programs to maximize funding available for FQHC infrastructure development. In the program under consideration, a state investment of \$55 million in CDBG or other grant funds could leverage approximately \$38 million in NMTC private sector investments and an additional \$33 million in HRSA or USDA-guaranteed low-cost loans. This pool of \$126 million for infrastructure investments would enable FQHCs to expand significantly to meet the primary care needs of communities across the state while leveraging the state's scarce resources to best advantage. The entire initiative will yield 179 additional health center sites, and ultimately provide health care to an additional 544,000 Louisianans.

Policy Request: Provide Health Care Services to an Additional 25,754 Louisiana Residents through a State Legislative Appropriation of \$5 million To Subsidize the Cost of Providing Care to the Uninsured

- The number of uninsured Louisiana residents served by Louisiana's Health Centers has grown substantially through the years. For example, in 2003 Louisiana's Health Centers served 41,369 uninsured users. In 2004, the number of uninsured users increased by 6,468, totaling 47,837. In 2005, the number of uninsured health center users increased by 12,489, totaling 60,326 uninsured users. Louisiana's Health Centers are seeking a State Legislative Appropriation of \$5 million dollars offset the cost of providing care to an additional 25,754 uninsured Louisiana residents. **An application has been submitted to Senator Mary Landrieu for the legislative appropriation.**

REQUESTS FOR FEDERAL INITIATIVES AND MANDATORY INTERVENTION

Strengths and Challenges

- Federal dollars were appropriated to the State of Louisiana for uncompensated care (UCC). Pursuant to the appropriations for reimbursement, Louisiana's CHCs submitted billable claims for UCC dollars post Hurricane Katrina prior to or by the deadline of June 30, 2006 only to be **denied UCC reimbursements by the state** whereas only a few centers received reimbursements. Furthermore, centers also **received denials for dental UCC service claims** as well.
- Pursuant to the request to serve as the point of primary care for the state of Louisiana efforts regarding its Pandemic Flu initiatives, Louisiana FQHCs accepted. Furthermore, we were asked to submit a concept paper for their grant application and responded to the request. As a result of the HRSA grant award to the state of Louisiana, Louisiana CHCs or LPCA **received no federal allocation within the grant award to the state for their collaborative efforts.**
- Louisiana's network of FQHCs has been largely endorsed by the Health Care Redesign Collaborative as the "right model" for medical home systems of care in New Orleans and other regions of the State. The *PAR Report* recommended a significant investment in developing the infrastructure of FQHCs so that greater access to primary care can become a reality for Louisiana citizens. Federal officials and other sources have fully supported and recommended this plan as the **most viable option** for a public/ private partnership in the State of Louisiana.
- In preparation for future disasters, LPCA, along with the Louisiana's Health Centers are currently developing an Emergency Preparedness Plan that conceptualizes a statewide network. While much has been accomplished over a relatively short period, LPCA is currently **limited by both operating funds and equipment to accede to the level of EP involvement that its potential represents to the overall state and regional efforts.**

The following governmental initiatives and/or requested mandates would greatly enhance the following collaborative efforts with the state of Louisiana:

- Federally mandate that the state of Louisiana set aside funding for primary care for FQHCs. Presently, federal funding is strictly dedicated to the hospitals in Louisiana.
- Expanded and specific inclusion of LPCA into all primary care federal grants (i.e. Emergency Preparedness such as Pandemic Flu and Bioterrorism; and other resources made available for the provision of/and related to primary care services) to include provisions that insure funding in primary care activities.

- Support for a broader role for non-governmental agencies in EP responses. (Primary care associations and In-Home care organizations are prime examples.)
- Assistance in securing the equipment (i.e. generators, radio and medical) necessary to fully integrate LPCA operations into supported agencies during all phases of catastrophic events.
- Assist in supporting funding for more mobile medical units.

LPCA seeks a “level playing field” and inclusion into all state primary care initiatives and processes. Assistance in acquiring the means to accomplish this is greatly appreciated.

LOUISIANA’S HEALTH CENTERS AND POST HURRICANE EFFORTS

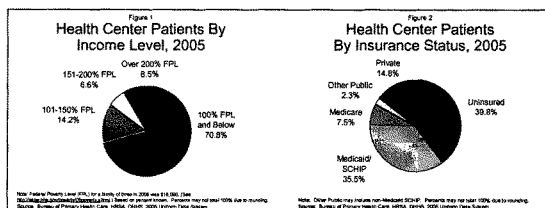
- LPCA successfully secured seven mobile units for Louisiana CHCs after the Hurricanes Katrina and Rita to help alleviate the barrier of transportation for hurricane evacuees. As a result, Louisiana FQHCs dispatched mobile units to emergency shelters and FEMA transitional housing sites within the southern region of the state.
- LPCA secured grant funding from Direct Relief International to provide medical transportation services for hurricane evacuees in FEMA and private transitional housing areas. Medical services were made available to over 200,000 hurricane evacuees in the Greater Baton Rouge area.
- In an effort thwart the significantly spiked mental healthcare disparities encountered by providers because of the hurricanes, the Louisiana Primary Care Association partnered with Morehouse College and IBM to provide training entitled “Psychological Response to Disaster”. The training educated over 160 attending healthcare providers on indicators and methodologies for treating patients suffering from PTSD and other behavioral health conditions.
- LPCA successfully secured grant monies from the Baton Rouge Area Foundation and Operations USA for Louisiana’s FQHCs. These funds provided placement of 14 providers—psychologist and licensed clinical social workers—to respond to mental health disparities.
- LPCA, in conjunction with HRSA, worked successfully in placing over 20 temporary medical providers throughout Louisiana FQHCs in response to the displaced evacuees needs.
- Presently, Louisiana continues to have displaced residents post Hurricane Katrina located in transitional housing areas. Louisiana CHCs continue to provide health services to all regardless of the ability to pay.

Community Health Centers: Working for America

WHAT ARE COMMUNITY HEALTH CENTERS?

Located predominantly in inner city and rural communities where health care is needed but scarce, America's community health centers **provide high-quality, affordable primary care and preventive services** to millions of people who typically have little or no access to care elsewhere. Today, community health centers serve as the family doctor and health care home for almost 16 million people in more than 5,000 communities across the country. As Figures 1 and 2 demonstrate, virtually all of their patients are from low-income families, and more than 80 percent are either uninsured or rely on public insurance coverage.

Community health centers bring good health to needy communities, without regard to family income, health insurance status, race, culture or health condition. Health centers have compiled a remarkable record of achievement in providing care of superior quality, with exceptional cost-effectiveness and efficiency. Their costs of care rank among the lowest, and they reduce the need for more expensive in-patient and specialty care, saving billions for taxpayers and society. The program has been ranked one of the 10 most effective federal programs by the Office of Management and Budget, and the top competitive grant program within HHS.



WHAT IS THE SECRET OF COMMUNITY HEALTH CENTERS' SUCCESS?

Community health centers possess several key features that make them unique within our healthcare system:

- ✓ **Every health center is located in a high-need area**, identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice;
- ✓ **Each health center is firmly grounded in its local community**, governed by patient-majority boards that ensure a focus on the community's most pressing needs – a feature unmatched anywhere else in our healthcare system;
- ✓ **They occupy the most opportune place in the health care system**, at the entry point, where quality preventive and primary health care, and committed management of chronic conditions, can yield both better care and enormous system savings, averaging 30 to 34 percent in total Medicaid spending for their patients.
- ✓ **They make their care affordable to everyone, regardless of ability to pay**, removing barriers that cause too many to delay necessary care or to use costly alternatives such as ERs. In fact, the cost of care at a health center is \$250 less annually per patient than the same care provided by private physicians.
- ✓ **They are held to high standards for performance and accountability** by federal program managers, and by each other – leading the prestigious Institute of Medicine to praise them for “providing care...of better quality and lower costs,” and to recommend them as models of primary health care.

* The term Community Health Centers includes all community, migrant, homeless, and public housing health centers that receive funding (or are eligible to receive funding) under Section 330 of the Public Health Service Act.

HOW DO COMMUNITY HEALTH CENTERS MAKE A DIFFERENCE?

Community health centers remove common barriers to care by serving communities who otherwise confront financial, geographic, language, cultural and other barriers, making them different from most private, office-based physicians. Community ownership of health centers assures responsiveness to local needs, and helps guarantee that health centers improve the quality of life for millions of patients in the following ways:

- ✓ **Improve Access to Primary and Preventive Care.** Health centers provide preventive services to vulnerable populations that would otherwise not have access to certain services, such as immunizations, health education, mammograms, pap smears, and other screenings. Uninsured health center patients are much more likely to have a usual source of care, less likely to have an unmet medical need, less likely to visit the emergency room or have a hospital stay, and more likely to have had a general medical visit than the uninsured nationally.
- ✓ **Cost-Effective Care.** Care received at health centers is ranked among the most cost-effective anywhere. Several studies have found that health centers save billions in annual Medicaid spending for health center Medicaid beneficiaries due to reduced specialty care referrals and fewer hospital admissions, saving billions in combined federal and state Medicaid expenditures. If avoidable visits to emergency rooms were redirected to health centers, over \$18 billion in annual health care costs could be saved nationally.
- ✓ **High Quality of Care.** Studies have found that the quality of care provided at health centers is equal to or greater than the quality of care provided elsewhere. Moreover, 99% of surveyed patients report that they were satisfied with the care they receive at health centers.
- ✓ **Reduction of Health Disparities.** Several studies have concluded that disparities in health status do not exist among health center patients, even after controlling for socio-demographic factors. The Institute of Medicine's landmark 2002 report, *Unequal Treatment*, recognized the importance of health centers in increasing access to care and in improving health outcomes for all patients, especially minorities; and a recent study in *Health Affairs* found that expanding health centers would lead to reduced disparities for minorities and the uninsured.
- ✓ **Effective Management of Chronic Illness.** Health centers meet or exceed nationally accepted practice standards for treatment of chronic conditions. In fact, the Institute of Medicine and the General Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. Health centers' efforts have led to improved health outcomes for their patients, as well as lowered the cost of treating patients with chronic illness.
- ✓ **Improve Birth Outcomes.** Communities served by health centers have much lower infant mortality rates than comparable communities not served by health centers, and low-income women receiving prenatal care at health centers have lower rates of low birth weight compared to all such mothers. In fact, a recent study found that if the success of health centers in lowering rates of low birth weight were achieved nationally, there would be 17,000 fewer low birth weight black infants annually.
- ✓ **Create Jobs and Stimulate Economic Growth.** Health centers employ nearly 100,000 full-time employees most of whom are local community residents. They bolster local business, sustain vital community services like pharmacies, and stabilize neighborhoods by stimulating community development and economic growth.

WHY IS INVESTING IN COMMUNITY HEALTH CENTERS IMPORTANT?

An expansion of community health centers would quickly address the needs of the underserved across our nation and be a critical step in transforming our health care system. Health centers improve the health of the patients and communities they serve by providing cost-effective, regular primary and preventive care that translates into reduced hospitalizations, lower use of emergency rooms, and fewer referrals to costly specialists, reducing overall health care spending significantly and producing far better health care outcomes. As a result, pressure on local emergency rooms will be lowered, saving tax payers significantly. Health centers are an excellent public investment that generates substantial benefits for patients, communities, insurers, and governments – indeed, for all of America.

GARY WILTZ, M.D. ANSWERS TO SUBMITTED QUESTIONS

QUESTION SUBMITTED BY HON. GENE GREEN

I am a strong proponent of health centers and understand the tremendous job the do to serve the uninsured. The cities of Houston and New Orleans both have high levels of uninsured with too few FQHCs to meet the need. So, I appreciate the challenges you face.

I understand that you have worked with Governor Blanco to craft a proposal for health center construction. Can you provide the committee with additional details on that proposal and explain how it will be utilized to leverage additional health care financing?

Additionally, with health centers saving three Medicaid dollars for every one federal dollar spent on them, there is no question that FQHCs are a good use of scarce health care dollars. As we look at rebuilding health care in New Orleans, can you on what role FQHCs will—or should—play in the reconstruction of the health care system?

For the first time in Louisiana Federally Qualified Health Center's (FQHC) history, a one time special capital outlay set aside has been allocated with the Governor's budget to expand existing site and service expansion initiatives. Louisiana Primary Care Association (LPCA) is currently working with Capital Link, Inc. to develop a capital funding program for FQHCs that would leverage New Market Tax Credits (NMTC) funding and HRSA or USDA Loan Guarantee Programs to maximize funding available for FQHC infrastructure development. The program under consideration would require a state investment of \$55 million in CDBG or other state funds to leverage approximately \$38 million in NMTC, private sector investments and \$33 million in HRSA or USDA guaranteed low-cost loans. This pool of \$126 million would fund the expansion and new site development of 58 health centers and the acquisition of 11 electronic medical record (EMR) systems. The health center expansion and new access point initiative is projected to provide health care to an additional 180,000 Louisianans.

Subsequent to the tragedies of Hurricanes Katrina and Rita, health officials within the state have deemed FQHCs as a viable option for public and private partnering as Louisiana reengineer its fragile health care infrastructure. Louisiana currently ranks 50th in the nation in poor health indicators, and the cost of health care is spiraling upward due to unwarranted emergency room visits to Louisiana's charity hospitals. The average cost per ER visit is \$383. Nevertheless, the average cost to see that same patient in one of Louisiana's Health Centers is \$130. Louisiana's Governor Kathleen Blanco has expressed on several occasions the need for a better community based system of care. The Louisiana's Health Care Redesign Collaborative has echoed the same sentiment proposing the "medical home" concept as the model for redesigning Louisiana's health care system. The medical home concept includes four basic components which are similar to the federally qualified health center's model—access to a primary care physician (PCP), an insurance connector, a Quality Forum and a health information technology system.

Most importantly, Louisiana's FQHCs are staffed by PCPs and nurse practitioners. Louisiana's FQHCs provide dental and mental health services, access to prescription assistance programs and the 340B program which provides for lost cost and in some cases free prescription drugs. The majority of Louisiana's FQHCs are Certified Medicaid Application Centers which serves as an "insurance connector". FQHCs are governed by a 51 percent consumer majority board similar to that of the Quality Forum—the establishment of a forum to oversee the quality of the care provided by the Medical Home. Additionally, many of Louisiana's FQHCs are JCAHO accredited or are applying for re-accreditation.

QUESTION SUBMITTED BY HON. ED WHITFIELD

Ms. Diane Rowland stated that pre-Katrina New Orleans had only two federally qualified health centers (FQHCs). Can FQHCs play a larger role in New Orleans? If so, what impediments do you see to the expansion of FQHCs at the federal, state, and local level?

There are two Federally Qualified Health Center organizations in New Orleans. One is the New Orleans Health Department Healthcare for the Homeless Program and the other is EXCELth, Inc. which operates the EXCELth, Inc. Primary Care Network (the EXCELth Network). The Health Care for Homeless program takes in more than its traditional population as a result of the effects of Katrina. As a network, the EXCELth Network has multiple sites in Orleans, Jefferson and East Baton Rouge Parish. Two sites are operated by the Daughters of Charity Services

of New Orleans in Orleans Parish and one more in Jefferson. Two EXCELth Network sites are operated by the New Orleans Health Department in Orleans Parish. There is another EXCELth clinic in East Baton Rouge, as well as, two mobile medical units operated by EXCELth, Inc. in New Orleans and East Baton Rouge (that goes mainly FEMA trailer sites).

However, there are additional FQHCs in the New Orleans Metro area. Jefferson Community Health Care Centers (JCHCC) is an FQHC in adjoining Jefferson Parish. St. Charles Community Health Care Center (St. Charles) operates in St. Charles Parish and in Kenner, LA, part of Jefferson Parish.

In post-Katrina Metro New Orleans, the collaboration between the FQHC organizations has been remarkable in that they have worked together to expand services by sharing their resources. The organizations regularly meet among themselves and other safety net providers to plan services to assure that gaps are addressed. A case in point is the March of Dimes Mobile Pre-Natal Van (The MOM Van). Collectively the EXCELth, JCHCC, Daughters of Charity and St. Charles Health Centers submitted a successful proposal to the national March of Dimes to operate the Mobile unit to outreach underserved communities in the combined Orleans and Jefferson area. Each has taken different roles to assure coordination and comprehensive care of this population at particular risk due to the loss of pre-natal providers in the area.

In this respect, the best solution for addressing the needs of the New Orleans area is to support the existing organizations that have bonded together and increased their capacity to provide community solutions. Additional, support to these organizations will increase their collective capacity and the opportunity for success.

Impediments that affect these health centers are generally the difficulties in quick resolution to financial and policy needs at Federal and state levels. Most have seen increased uncompensated costs (uninsured rates have increase to 80 percent in some sites of service). While block grants have helped, the limited and unpredictable length of their existence impedes practical planning of service delivery and response. Additionally, long term support for increasing workforce availability is also critical.

